United States of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 111th CONGRESS, FIRST SESSION

Vol. 155 WASHINGTON, TUESDAY, JANUARY 27, 2009 No. 16

Senate

The Senate met at 10 a.m. and was called to order by the Honorable JEANNE SHAHEEN, a Senator from the State of New Hampshire.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Eternal God, our helper and friend, guide our Senators this day. Help them to walk the way of surrender to Your will, guided by Your wisdom. Refresh them with Your spirit to quicken their thinking and reinforce their judgment. Show them the spiritual foundations of our heritage that they may conserve and protect them. Draw them close to You and to one another in humility and service. And, Lord, spare them from arrogating to themselves the judgments which belong to You alone.

We pray in Your wonderful Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable JEANNE SHAHEEN led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, January 27, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable JEANNE SHAHEEN, a Senator from the State of New Hampshire, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. SHAHEEN thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Madam President, following leader remarks, the Senate will resume consideration of the Children's Health Insurance Program. At about 12:30 p.m. today, KIRSTEN GILLIBRAND will take the oath of office to become a Senator representing the State of New York. Following the swearing in of that Senator, the Senate will recess until 2:15 p.m. to allow for the weekly caucus luncheons to meet.

This week, we are going to legislate. There will be no morning business. We want to have all the time that is necessary to work on this important legislation dealing with children's health. I hope people will be ready to offer amendments. We have worked with staff on the Republican side of the aisle, and we have it set up that we have three amendments that will be laid down very quickly. By that time, we should be able to even schedule some votes for this afternoon.

I want to make sure everyone has the opportunity to offer any amendment they want to offer. What we are going to try to do is not have a bunch of them stacked up. I think that can sometimes be very troublesome. But we will work, as we proceed through the legislation, as to what amendments need to be pending. We are here to legislate. We hope that if people have concerns about this important legislation and they think it can be made better by taking something out or putting something in, that is what they should do. We want everyone, when they offer their amendments, to have ample time to debate them, as we did with the first piece of legislation we dealt with, the Lilly Ledbetter legislation. After there has been ample time for debate, there can be motions to table. There are some Senators who may, for various reasons, agree to have up-or-down votes. We are here to legislate.

This morning is a little difficult because we have the Finance Committee meeting to complete their work on the recovery package. There are 200 amendments that have been filed in the committee, and they have to work their way through those amendments. That should take the better part of the day, at least many hours. It is estimated from 4 to 8 hours to complete the markup.

The Appropriations Committee markup is at 10:30 a.m. also. There are people from the Finance Committee who will be coming here on a rotating hour-by-hour basis so there will be floor coverage. So there is no reason not to be able to legislate and talk about this legislation in any way Senators feel is appropriate. Rollcall votes are expected to occur throughout the day. There will not be any votes before we complete our caucus luncheons.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

ORDER OF BUSINESS

Mr. MCCONNELL. Madam President, are we now on the bill?

The ACTING PRESIDENT pro tempore. The bill has not yet been laid down.

Mr. MCCONNELL. Can I suggest we go to the bill? I was going to lay down an amendment, consistent with the majority leader's suggestion that we get started.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate shall resume consideration of H.R. 2, which the clerk will report.

The legislative clerk read as follows:

A 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.

The ACTING PRESIDENT pro tempore. The majority leader.

AMENDMENT NO. 39

(Purpose: In the nature of a substitute)

Mr. REID. Madam President, there is an amendment at the desk that I wish the clerk to report.

The ACTING PRESIDENT pro tempore. The clerk will report.

The legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. BAUCUS, proposes an amendment numbered 39.

Mr. REID. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

The ACTING PRESIDENT pro tempore. The Republican leader.

AMENDMENT NO. 40 TO AMENDMENT NO. 39

(Purpose: In the nature of a substitute)

Mr. MCCONNELL. Madam President, I support the State Children's Health Insurance Program. I think virtually every Member of the Senate does. I voted to create the program and believe we need to responsibly reauthorize it.

In its original form, the State Children's Health Insurance Program was meant to provide insurance to children from families who earn too much to qualify for Medicaid but not enough to afford private insurance.

There is no doubt, as I indicated earlier, we all support providing insurance to low-income children. I am sure that is 100 Members of the Senate. In fact, this program originally passed on a broad bipartisan basis with 43 Republicans and 42 Democrats supporting it. It was enacted by a Republican Congress, signed by a Democratic President, and was a model of bipartisanship. Two of my colleagues, Senator GRASSLEY and Senator HATCH, reached across the aisle to craft a bipartisan compromise in the last Congress. Unfortunately, our Democratic colleagues have gone back on many of the prior agreements that were reached in creating that bill last year, making this issue more contentious than it ought to be and setting a troubling precedent for future discussions on health care reform.

The original purpose of the State Children's Health Insurance Program was to serve low-income, uninsured children. The bill we are being asked to consider sanctions a loophole that allows a few select States, such as New York, to provide insurance to children and families earning more than $80,000 a year—$80,000 a year—instead of insuring low-income children first. This is more than double the median household income in many States, including my State of Kentucky. It is grossly unfair that a family in Kentucky making $40,000 must pay for the health insurance of a family making double that, especially if the Kentuckian cannot afford it for his own family.

The bill before the Senate is not limited to children either. It preserves loopholes that allow adults to enroll in a program that is intended for children.

Earlier estimates of similar legislation found that nearly half of the new children added by this bill already have private health insurance. Let me say that again. Earlier estimates of similar legislation found that nearly half of the new children added by this bill already have private health insurance. Republicans, on the other hand, believe we ought to target scarce resources to uninsured children, not those who already have coverage.

Republicans will offer amendments to fix the shortcomings of this bill and to provide a responsible alternative that will return SCHIP to its intended purpose: serving the kids in struggling families who need the help most. That is whom we ought to be helping.

Our bill, the Kids First Act, will provide funding increases to State SCHIP programs and help them find those eligible children who are not yet enrolled, and our Kids First idea is better because it closes the loophole that allows some States to extend their program to higher income families, even while they have thousands of lower income children who still are not covered. The Kids First Act truly puts kids first, eliminating nearly all adults from a program designed for children so that more children can be covered. Finally, by responsibly allocating scarce resources, our bill increases funding for SCHIP without raising new taxes. We believe Republicans have a better alternative.

Madam President, I now send that alternative to the desk.

The ACTING PRESIDENT pro tempore. The clerk will report.

The legislative clerk read as follows:

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 40 to amendment No. 39.

Mr. MCCONNELL. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

The ACTING PRESIDENT pro tempore. The Senator from Illinois.

Mr. DURBIN. Madam President, we are now commencing debate on the Children's Health Insurance Program. I wish to speak to the amendment that has been offered by Senator MCCONNELL, as well as the pending legislation.

It is a grim reality in America that each day, 17,000 Americans are losing their jobs. Each day, 9,000 Americans are facing new mortgage foreclosure notices. Madam President, 17,000 lost jobs and 9,000 have lost homes. In the process, some 11,000 Americans are losing their health insurance every single day. So the issue that was before us when we created the Children's Health Insurance Program has become gravely worse, and we are finding more and more Americans who are being squeezed out of health insurance coverage—46 million uninsured Americans today, including 9 million children.

We decided to make children a priority in terms of providing health insurance. What the Federal Government said to the States was: We will come up with a program, but we will give you more than the normal Medicaid share; we are going to give you a share that is enhanced so that you will consider covering these uninsured children. In that situation, many States took advantage of it.

I might just say, Madam President, that I understand Senator GRASSLEY is in the Chamber and has a 10:30 a.m. Finance Committee meeting and I have a 10:30 a.m. Appropriations Committee meeting. Let me do my best to share the time so I can leave him with the remaining 10 minutes or so. Is that fair? I want to make sure Senator GRASSLEY has a chance because we have to go to important meetings.

The difficulty we face today, the reality is we wanted this program primarily to help families making up to 200 percent of what we call median family income. That would basically mean they would be making roughly up to $42,000 a year. So if you are making $42,000 or less, we want those kids covered.

Then we said to the States: You can go as high as 300 percent, and that would take it up to $63,000. You would have to pay more for that out of State funds if you think that group of kids of families making between $42,000 and $63,000 need the help. And some States took advantage of it.

Then there were two exceptions, as I understand it. High cost of living States—New York and New Jersey—asked for permission to go even higher, up to $77,000 to $83,000 I think was the annual income. When many of the critics of this legislation, including the Republican leader, who just spoke, talk about what is wrong with it, they point to New York and New Jersey. I can tell you those are rare exceptions to the rule across America. By and large, this program is geared for people with incomes below $42,000 a year, and in some

cases below $63,000, with only two exceptions that I know, New York and New Jersey. And I will stand corrected if there is another State.

But the point is, to argue that this is a program that is for the wealthiest among us is to ignore the obvious. Those two States notwithstanding, people making $63,000 a year I do not put in the category of wealthy. Certainly, those making $42,000 I wouldn't at all. In fact, they are almost smack dab in the middle of the middle-income families in America. When they face the cost of insurance not covered by their employer, it can be an extraordinarily high expense. That is why many of them opt out of coverage for the family, which means mothers, fathers, and children go without health insurance. Imagine making $42,000 a year and seeing a third or 40 percent of your income going into FICA and taxes. What does that leave you with, about $2,000 a month? And with $2,000 a month, how many families can realistically turn around and buy a health insurance plan on the private market?

I also worry about this argument that we want to trap people into private health insurance that could be a bad policy that is very expensive, instead of giving them an option of coming into the Children's Health Insurance Program. If our goal is to give these families affordable health insurance, then why do we want to trap them in a private plan? Some will stay with the private plan because they are happy with it; others have a plan that, frankly, has a high deductible, high copay, limited coverage, and high cost. We want to trap those families in that plan?

Sadly, the amendment that is offered by Senator MCCONNELL has a mandatory 6-month waiting period between leaving private health insurance and enrolling in CHIP. What kind of benefit is that for the families of Illinois or Kentucky who are in a bad private health insurance plan—the only one they can afford? We want to give them real insurance that can be there when they need it.

We know there are families who desperately will need help. I have here the photograph of a family from Illinois. It is a classic story. This is a family, Steve and Katie Avalos and their son Manolo. In 2005, Katie became pregnant while Steve was still in law school, and because of Federal programs such as CHIP and Medicaid, the State of Illinois was able to provide health coverage for Katie through the All Kids Program. With help from St. Joe's Hospital, Katie was enrolled in the Illinois Moms & Babies Program. She received excellent prenatal care. In February 2006, her beautiful little baby boy Manolo was born with a rare neurologic condition that affects his balance, coordination, and speech. He was living with something called Dandy Walker Syndrome and as a result has had slow motor development and progressive enlargement of his skull.

Because Manolo has a preexisting condition, his options for health insurance are very limited. Yet with All Kids, our version of the Children's Health Insurance Program in Illinois, Katie can give her child the services that are important building blocks for his future success. Katie is grateful for reliable health insurance. Without it, Manolo would not have experienced his many successes. He was able to walk at age 2½, and the family is so happy. Without that helping hand, without the rehab and the special medical care, that might never have happened. Manolo turns 3 in a few days, on February 2, and he has his whole life in front of him.

Was this a bad investment, investing in this family, investing in this child, giving them a chance for the medical care they needed so this little boy has a normal life? When I hear from critics who argue that this is something we can't afford, or unfortunately it is going to crowd out private health insurance, I wonder if they know what a private health insurance plan would have cost this family with a child with a preexisting condition. They would have been lucky to find one they could afford, and it would have had many exclusions and many riders.

Now Senator MCCONNELL says to this poor family, stick with it for 6 months no matter what it is costing, no matter the fact that it doesn't cover what your child needs. I don't think that is the way to go. I think what we have to understand is that many people came together, Democrats and Republicans, to pass this bill initially—to pass it twice, though it ended up with President Bush's veto—and in all of these instances we were affirming the bottom line. And the bottom line, as President Obama and others have said, is health insurance is critically important for all of us.

President Obama said:

> People don't expect government to solve all their problems. But they sense deep in their bones that with just a slight change in priorities, we can make sure that every child in America has a decent shot at life and that the doors of opportunity remain open to all. They know we can do better.

Those are the words of President Obama in his speech to the 2004 Democratic convention. I know deep in our bones the Senate will stand together to give an additional 4 million kids coverage with health insurance. A bill that had been vetoed twice by President Bush can become the law of the land so this family—this loving family with a beautiful little boy—and thousands of others like them have a chance at quality health insurance.

I might conclude by saying that this debate is important for the course of the Senate, because all of us understand we have had some tough times on the Senate floor over the last couple of years—95 filibusters, a record-breaking number. What we want to do this week is to prove, as we did last week, that we can have amendments offered constructively; that we can debate them, deliberate them, and vote on them in an expeditious way. We can have a fair hearing on these amendments and come to a vote and not face a cloture vote and 30 hours of the Senate sitting in quorum calls with nothing happening. But it takes a cooperative effort on both sides. I think we can reach that again, and I hope we will prove it this week and by the end of the week pass this critical legislation to give 4 million kids, such as Manolo here, a chance for a better life.

Madam President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Iowa.

Mr. GRASSLEY. Madam President, our goal is to cover 4 million kids, as was spoken by the majority whip. Our goal is to do it in a way so that we actually have the resources to cover children who do not have health insurance.

There are some aspects of the underlying bill before us that would lead families to drop private health insurance, and I am cognizant of what Senator DURBIN said, that if you have a bad policy, maybe you ought to be on SCHIP. I don't dispute that. But we have found that when you crowd people out of private health insurance, it is more apt to happen at the highest income levels than at the levels he was talking about, where we ought to be helping people under $42,000.

Then there is another category where they want to help people that sponsors have already assumed the responsibility of making sure their health care would be covered. In that category, we find $1.3 billion being wasted that we can take and use on children who don't have coverage.

So there is no dispute about covering 4 million people. There is a dispute about whether we ought to encourage people who are of higher income to drop out of private policies and to go on the Children's Health Insurance Program. If you talk to people in the Congressional Budget Office—the nonpartisan Congressional Budget Office—you will find that is a fact. Then when we have people sign a contractual relationship with the Federal Government that they are going to provide for the needs of the people they bring into this country, we feel—at least for a period of 5 years, and that is present law—that they should maintain that contractual relationship they have with the government; otherwise, those people would not be here in the first place. So we want to cover 4 million people. We want to cover people who don't have insurance. We don't want to encourage higher income people who do have insurance to go into the State health insurance program, and we want to make sure that people maintain their contractual obligations.

We are going to offer a series of amendments today and tomorrow to bring out these differences between the two approaches, but I am not going to stand by and let anybody on the other side of the aisle say there is a dispute

about covering 4 million people. I will make the point on this side of the aisle that we want to make sure we put emphasis upon covering people who don't have insurance, where they are willing to look at encouraging people to leave private insurance and go into a State-run program or encouraging people to avoid their contractual obligations with the Federal Government. Using our approach, it seems to me, the goal then can be reached so we actually reach more people who don't have insurance.

AMENDMENT NO. 41 TO AMENDMENT NO. 39

Now, the first amendment I am going to offer deals with this issue I referred to as a contractual obligation. The amendment I am offering today is very simple. It increases the coverage of low-income American children currently eligible for Medicaid but who are uninsured relative to the bill before this Senate. My amendment does this by striking the Federal dollars for coverage of legal immigrants and uses those funds to cover more low-income American kids instead.

Let me make it very clear: Whichever bill passes, we are talking about 4 million more kids, but we are still talking about a lot of kids who still aren't going to have coverage that we ought to be concerned about. So this is all about priorities. The Congressional Budget Office has reviewed my amendment and it indeed does the job of covering more low-income American kids. In fact, my amendment will get as many or more low-income American kids health coverage than the majority's bill does with the coverage of legal immigrants.

Does that sound right? It is right. It does not reduce the number of kids covered. It covers as many low-income kids, and maybe even more. The difference is that the additional low-income kids who get health coverage with my amendment are U.S. citizens. It does a better job of enrolling these low-income children than the bill before the Senate. I thought that covering children who were eligible for Medicaid but who were insured was a bipartisan goal shared by my Democratic colleagues. This amendment does exactly that.

I want to get back to the background on the amendment. In other words, there are people who are legally in the country—no dispute about that, legally in the country—who have sponsors. Without the sponsors, they would not be here. Those sponsors have signed an agreement with the Federal Government for these people to come into this country, that they will take care of them for 5 years, that they will not become a public charge. So those sponsors promised for their needs so that they would not be on programs that come out of the Federal Treasury, or else they would not be here. That is a cost of $1.3 billion when you are going to let those people not honor their contractual relationships and allow them to go on the Children's Health Insurance Program. And are they any better off? No, because the people who brought them here promised they were going to fulfill those needs and not become a public charge. But we would take that $1.3 billion and spend it on people who were not promised any coverage but qualify for the Children's Health Insurance Program and cover more kids in the process.

Madam President, I am going to send my amendment to the desk, and I ask that it be read.

Before I do that, I am sorry, I have to ask unanimous consent to set the pending amendment aside.

The ACTING PRESIDENT pro tempore. The amendment is in order at this time, and the clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for himself, Mr. HATCH, Mr. ROBERTS, and Mr. VITTER, proposes an amendment numbered 41 to amendment No. 39.

Mr. GRASSLEY. Madam President, I ask unanimous consent that the reading thus far constitute the reading.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The text of the amendment is as follows:

(Purpose: To strike the option to provide coverage to legal immigrants and increase the enrollment of uninsured low income American children)

Strike section 214 and insert the following:

SEC. 214. INCREASED FUNDING FOR ENROLLMENT OF UNINSURED LOW INCOME AMERICAN CHILDREN.

Section 2105(a)(3)(E) (42 U.S.C. 1397ee(a)(3)(E)), as added by section 104, is amended by adding at the end the following:

''(iv) INCREASE IN BONUS PAYMENTS FOR FISCAL YEARS 2012 THROUGH 2019.—With respect to each of fiscal years 2012 through 2019:

''(I) Clause (i) of subparagraph (B) shall be applied by substituting '38 percent' for '15 percent'.

''(II) Clause (ii) of subparagraph (B) shall be applied by substituting '70 percent' for '62.5 percent'.

Mr. GRASSLEY. Madam President, did I make a mistake, that I was not supposed to set the amendment aside? I apologize if I made a mistake.

The ACTING PRESIDENT pro tempore. The Senator can proceed at this time without consent.

Mr. GRASSLEY. I have said all I am going to say, and from that standpoint, we will be debating this amendment throughout the day. We do not object to what the majority leader said, that he would like to vote on these amendments today. I think it is our intention to do that sometime during the day.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Utah.

Mr. HATCH. Madam President, as someone who considers the creation of the CHIP program one of my happiest legislative accomplishments as a Senator, this is a very difficult and disappointing week for me. Like the rest of the Nation, after this historic election, I was so hopeful we would mark this new era with the passage of bipartisan CHIP legislation. However, the partisan process engineered by the other side of the aisle so far on this issue of great importance, has only reinforced the American people's cynicism about Washington's partisan political games. Americans are tired of this, and I am tired of this. Change is not just a slogan on a campaign poster, it is about real action.

I began this year with great hope that we would all come together to complete our work from 2007 and have a bill signed into law that would have overwhelming support on both sides of the aisle. But that hope has turned quickly into disappointment and the promise of change into a commitment to remain the same.

It appears that decisions were already made without those of us who worked morning, noon and night for several months in 2007 to create a bipartisan CHIP bill not once, but twice at the consternation of many colleagues on my own side. And I want to make one point perfectly clear to my colleagues in this chamber—Senator GRASSLEY and I were willing to roll up our sleeves and do it again this year. That is because we remain committed to those 6 million low-income, uninsured children who are eligible for CHIP and Medicaid coverage.

I am bitterly disappointed by the outcome of this bill. CHIP is a program I deeply love and built with my friends and colleagues who share my concern about the welfare of uninsured children of the working poor—the only ones who were left out of this process.

Again, in the Senate, we could have had a bill that would have brought the vast majority of members together once and for all to help these children. But that was not to be.

When our new President was campaigning across the country, he made a promise to the American people that he would invoke change and end the bitter partisanship on Capitol Hill. I find it ironic that he will be meeting with GOP members to talk about bipartisan efforts in the economic stimulus package the same week that the Senate is about to pass the very first partisan CHIP bill. The other three bills that this body has passed on the CHIP program were approved with overwhelming bipartisan support—69 votes for; both parties.

When President Obama was elected, I truly believed his promise of bipartisan change. And at risk of sounding overly sarcastic, I believe that if this bill and the process so far on the stimulus legislation are any indicator of what the future will bring, the American people will demand to know exactly what kind of change the Democrats pledge to bring to Washington.

I know my colleagues will agree that we put our hearts and souls into negotiating the reauthorization of the CHIP program in 2007. We stuck together through some very tough decisions—whether or not to allow coverage of pregnant women through CHIP, whether or not to continue coverage of childless adults and parents, whether

or not to allow States to expand CHIP income eligibility levels, how to eliminate crowd-out and, most important, how to get more low-income, uninsured children covered through CHIP. We had some tough discussions, but in the end, we ended up with two bills, CHIP I and CHIP II, that covered almost 4 million low-income, uninsured children. Unfortunately, neither version of the bill was signed into law and, in the end, we simply extended the CHIP program through March 2009.

Back then, we knew that we needed to prepare, once again, for another debate on the reauthorization of the CHIP program in early 2009. But we all felt that the outcome would be different and that the legislation that I developed with Senators GRASSLEY, ROCKEFELLER and BAUCUS which I believe greatly improved the CHIP program, would be signed into law.

While the CHIP legislation that we passed in the Senate was not perfect, which we fondly refer to as CHIPRA I and CHIPRA II, it represented a compromise and laid the foundation for bipartisanship and trust that was integral to getting the legislation not once but twice to the President's desk.

The bill being considered this week is not that bill because it includes provisions that I feel were not part of our bipartisan agreement such as the inclusion of a State option to cover legal immigrant children and pregnant women. Amendments will be offered to improve this legislation but if they are not accepted, I will not be able to support this bill. And I deeply regret it.

I started putting together ideas regarding the CHIP program after I met with two Provo, UT, families in which both parents worked. Each family had six children. Neither family, with both incomes, had more than $20,000 a year in total gross income. They clearly could not afford health insurance for their children. CHIP was the only answer to their plight. They were the only people left out of the process. They worked. They did the best they could.

When Senators KENNEDY, ROCKEFELLER, CHAFEE and I wrote this program in 1997, we wrote it with the intent of helping the children of those Provo families and others like them. Our intent was to help the children of the working poor, the only children who did not have access to health coverage back then. These children's families made too much money to qualify for Medicaid and not enough money to buy private health insurance.

In addition, it came to light that both the Clinton and Bush administrations permitted individuals to be covered by CHIP who did not fit the definition that we had in mind for children of the working poor. In fact, they were not even children. They were childless adults and parents of CHIP eligible children. My good friend Senator GRASSLEY likes to remind us that there is no ''A'' in the CHIP program. There is only a ''C'' and we all know what that ''C'' stands for and it is not adults.

I believe that having adults on this program caused the price tag of CHIP to escalate and even led to some States running out of their CHIP allotments prematurely. To add insult to injury, because States receive a higher Federal matching rate for covering individuals in the CHIP program, States were given financial incentives to continue covering adults.

As part of our compromise in 2007, childless adults would have been phased off CHIP and transitioned to their States' Medicaid programs. Parents would have been covered in a capped program and within a set timeframe, States would have either received the Medicaid matching rate or the matching rate half way between the State's Medicaid matching rate and the CHIP matching rate. This was called RE-MAP. States would have only gotten the RE-MAP Federal match if they covered a certain number of low-income children.

Our two bills from 2007, CHIPRA I and CHIPRA II, brought this situation to light and put a stop to covering future adults once and for all. In fact, States will no longer be allowed to submit waivers to cover adults through the CHIP program once the bill before the Senate becomes law. That seems right.

We have also seen some States cover children whose family income is well above 200 percent of the Federal poverty level. Typically, these higher income families have access to private health insurance so they end up having a choice between private health insurance, paid for in part by their employers, or CHIP coverage, almost fully paid for by the Federal and State governments.

Unfortunately, many of these families end up choosing CHIP over private health coverage, thus contributing to higher costs incurred by the CHIP program. Adding higher income families to State CHIP programs also affects the Federal taxpayer who ends up paying for a significant part of the CHIP program.

And, once again, States currently receive the higher CHIP Federal matching rate for covering these higher income children. This is something that really bothers me because it is so contrary to the original goal of the CHIP program.

There are other issues as well—the crowd-out policy that we worked out to address the serious crowd-out concerns raised by Members was not included in this mark.

This policy, section 116 of CHIPRA I and CHIPRA II called for the Government Accountability Office, GAO, to study what States are doing to eliminate crowd-out in the CHIP program. In addition, the Institute of Medicine, the IOM, was directed to come up with the best way for measuring, on a State-by-State basis, the number of low-income children who do not have health coverage and the best way to collect this data in a uniform manner across the country. Today, there is no standard for States to collect data on the uninsured, including uninsured, low-income children.

So right now, it is a guessing game for States to figure out how many low-income, uninsured children reside in their States. To me, it is a no brainer that we should incorporate a standard way to collect this important information to help us figure out how many low-income, uninsured children still need health coverage.

The deleted section also required the Health and Human Services Secretary to develop recommendations on best practices to address CHIP crowd-out. It also directed the Secretary to develop recommendations on how to create uniform standards to measure and report on both CHIP crowd-out and health coverage of children from families below 200 percent of the Federal poverty level.

I simply do not understand why on earth the majority would drop such an important provision. I don't understand that since we worked so hard to solve these problems. Don't we want to eliminate crowd-out to ensure that the children in the most need are the top priority? Don't we want to make sure that the data collected in Utah on uninsured, low-income children is collected the same way across the country? Don't we want to compare apples to apples? Or is it possible that some in this body simply want to continue the guessing game and never truly know how many low-income, uninsured children live in their States?

We will have a vote on this provision during this debate and it is my hope that Senators on both sides of the aisle will want to have answers on crowd-out and appropriate data collection. I cannot believe that Members subscribe to the irresponsible, anything goes policy which is exactly what they are advocating if they vote against the amendment to add this provision back into the bill.

Another issue that is very important to me is the coverage of high-income children through the CHIP program. When we were negotiating CHIPRA I and CHIPRA II in 2007, we agreed 300 percent of the Federal poverty level for CHIP was high enough. CHIPRA I provided States with the lower Medicaid matching rate, FMAP, for covering children over 300 percent of FPL. CHIPRA II, the second bill vetoed by the President, went one step further and stopped all Federal matching rates for CHIP children over 300 percent of FPL. That is the policy that I support—there is no reason on earth that a family making $63,000 per year should be covered by CHIP and that a State should be rewarded with any Federal matching dollars for covering these high-income children.

In fact, there is one State that provides CHIP coverage up to 350 percent of FPL and another State that is trying to cover children up to 400 percent

of FPL. In my opinion, when States start moving in that direction, they are taking a block grant program, one that we felt should be operated by the States to help children of the working poor, to push towards a single payer health system. That is what they are pushing for. That is not what we agreed to in 1997 when we created CHIP.

However, the legislation before us today allows States that had submitted State plan amendments or had their waiver approved to increase their income eligibility levels to over 300 percent of FPL to receive the higher Federal matching rate for the CHIP program. These States are New Jersey, a State that now covers children up to 350 percent of the Federal poverty level and New York, a State that submitted a plan to CMS to cover children up to 400 percent of the Federal poverty level. I do not support this provision and will be supporting an amendment to prevent these two States from receiving the higher CHIP matching rate. that are willing to work within the limits we set and have worked well under the original CHIP bill.

Another issue that deeply troubles me is the insistence to include a State option to cover legal immigrant children and pregnant women, who are not citizens of our country, through the CHIP program.

In 2007, we made agreements that our legislation would not include the coverage of legal immigrant children and pregnant women. I have consistently voted against adding that new category, even if it is at the State option, because I believed then, as I believe now, that before we even consider expanding the CHIP program to legal immigrant children, we need to do the best job we can to cover the children of the working poor who are U.S. citizens.

While we have improved, we still have at least 6 million other children to cover, maybe more, with the dire economic conditions currently facing our country.

Now, before we even started drafting our first CHIP bill in 2007, we agreed that legal immigrant children would not be added to the CHIP program. That agreement was very important to me and to other Republicans who eventually supported the two CHIP bills that we negotiated in 2007.

In addition, we have always struggled to find sufficient dollars to reauthorize the CHIP program. The bill before the Senate is only a 4½ year reauthorization due to limited funds. I understand there is some extra money in the bill for the legal immigrant provision. I believe that we should be using that money to cover low-income uninsured children who are U.S. citizens first. How many children who are U.S. citizens will be without health care because we have decided to cover legal immigrants through CHIP?

I wish to know the answer to that question before this bill becomes law. Now, ordinarily I support helping legal immigrants in almost every way. But we do not have enough money to take care of our own citizens' children. That is a matter of great concern to me and it is of great concern to a significant number of Members of both bodies who probably will vote against this bill because of that provision. In fact, there are plenty of reasons to vote against this bill because it was written in such a partisan fashion.

I might add, the legal immigrant provision is now in this legislation, and, as a result, there are many Members in both Houses of Congress who now oppose the bill. We simply do not understand why we are not taking care of our children who are U.S. citizens first. Once that goal is accomplished, I would be willing to make a commitment to the work on resolving all of the issues regarding legal immigrants once and for all.

But now is not the time. There is not enough money even in this bill to take care of our children who are citizens. This is especially true when our country is in economic crisis and there are more children who are U.S. citizens who need health insurance coverage because their parents may have lost their jobs or may have lower paying jobs. I do not believe this is an unreasonable request. For the life of me, I cannot understand why those who support the coverage of legal immigrant children cannot work with us to resolve this issue, especially if they want a bill that has broad bipartisan support.

But without a doubt, the issue that broke down negotiations between the Senate and House Republicans at the end of 2007 involved Medicaid eligibility. Section 115 of the legislation would allow States to create higher income eligibility levels for Medicaid. When are we going to quit throwing money at programs?

Simply put, a State could establish one income level for Medicaid, a higher income eligibility level for CHIP, and then cover more kids at an even higher income eligibility level through Medicaid. In other words, a State could cover higher income children through Medicaid at an even higher income level than children covered by CHIP.

This provision sets no limits on the income eligibility level for Medicaid. Now, that is ridiculous. It is irresponsible. It is fiscally unsound. Everybody here knows it. In 2007, the House Republicans wanted to put a hard cap of 300 percent of Federal poverty level on State Medicaid programs. I agreed with them, but others did not. I am quite disturbed that the legislation before the Senate still allows States to cover high-income children under their State Medicaid plans. Technically speaking, section 115 of this bill would allow a State to cover children under Medicaid whose family income is over 300 percent, over $63,000 for a family of four.

During this debate, I intend to support and speak in favor of amendments to address this very serious concern of mine. It ought to be a serious concern of everyone here, since there a limited amount of money that may be used.

Additionally, section 104 of the legislation creates a bonus structure for States that enroll Medicaid-eligible children in their State Medicaid programs. The idea is to reward States for covering their poorest children. If a State increases its Medicaid income eligibility levels, using the language in section 115, additional children added to Medicaid would not be eligible for a bonus during the first 3 fiscal years. However, at the beginning of the fourth fiscal year, it is possible that States could receive a bonus for enrolling higher income children in their State Medicaid programs.

Now, this provision simply does not make any sense. I urge my colleagues to drop it once and for all. A State should not be rewarded for covering a high-income child in its State Medicaid program, especially when it is not going to be covering those who need to be covered and should be covered.

Well, I have to admit, Senator GRASSLEY and I went through a lot of pain on this side, and in the House of Representatives, bringing people together for the overwhelming votes that we did have in both the Senate and the House, but especially here in the Senate on both CHIPRA I and CHIPRA II.

Then, all of a sudden we find that since the Democrats have taken over and now have a significant majority, they do not need Senator GRASSLEY and me anymore.

Now, my feelings are not hurt, I want you all to know that. But I am disgusted with this process that is so partisan. I am particularly upset because everybody in this body knows that I fought my guts out to get the original CHIP program through to begin with in 1997. And it would not have happened had I not brought it up in the Finance Committee markup on the Balanced Budget Act. In fact, it became the glue that put the first balanced budget together in over 40 years.

So you can imagine why I feel the way I do. I know how badly Senator GRASSLEY feels. We are both conservatives, but we both worked our guts out trying to bring about an effective approach, and it was effective in CHIPRA I and CHIPRA II.

Unfortunately, in 2007, neither bill did not have enough votes to override a veto. I think our President had very poor advice, and anybody who looks at the mess this legislation is in right now, and the lack of bipartisanship, will have to agree that we should have signed into law either CHIPRA I or CHIPRA II. But then that is the past.

I hope my colleagues on the other side will recognize that some of us worked hard to try and bring about effective legislation, taking on our own administration, taking on wonderful friends on our own side, to bring about legislation that would work a lot better than the bill before us today. This bill, in my opinion, is going to lead to higher costs and less coverage of children.

Why? What is the reasoning behind it? Well, unless there are essential

changes made to this legislation during the floor debate, I will be voting against my own bill, and against the program I helped create in 1997. It is sufficient to say that I am not only disappointed, but I am angry. This entire debate has personally been grievous to me, because it has now become a partisan exercise instead of being about covering low-income, uninsured children, where we could have had a wonderful bipartisan vote. We could have made this third reauthorization bill a tremendous victory for the President.

Well, he may feel tremendous victory anyway, even though it is a partisan one. But I do not look at it that way. To start out the year on this note does not bode well for future health care discussions, including health reform and the Medicare bill that we will be considering this fall. In fact, one of the very first bills that the President, who ran on a platform of bipartisanship and change, will sign into law is going to be a partisan CHIP bill, produced as a result of the same old Washington gamesmanship. That is pathetic when you think about it, because we should be together on this bill, and a large majority would have voted again for legislation similar to either CHIPRA I or CHIPRA II.

I want to encourage the President and his colleagues to seriously consider what they are doing. We were so close to working out a bipartisan CHIP agreement and, in my opinion, I believe they are missing an incredible bipartisan health care victory by making this a partisan product. So I urge the President and my friends on the other side—they are my friends—I urge them to reconsider this strategy. I think we still have time to turn this around and make it the bipartisan bill many of us would like it to be. Ensuring access to quality and affordable care for Americans is not a Republican or Democratic issue, it is an American issue. Our citizens expect nothing less than a bipartisan, open, and inclusive process to address a challenge that makes up 17 percent of our economy and will increase to 20 percent within the next decade. A bipartisan CHIP bill would have been an incredible step in that direction.

However, once again politics has triumphed over policy, Washington over Main Street.

The famous novelist Alphonse Karr once said, ''The more things change, the more they remain the same.'' There is no better proof of this statement than this CHIP legislation. I continue to hope that the change promised in this election did not have an expiration date of January 20, 2009, but rather was a real and accountable promise to our citizens. There is no better place to start this change than on this CHIP bill by making it truly bipartisan.

Mr. President, I send an amendment to the desk.

AMENDMENT NO. 45 TO AMENDMENT NO. 39

The PRESIDING OFFICER. Without objection, the pending amendment is set aside. The clerk will report.

The legislative clerk read as follows:

The Senator from Utah [Mr. HATCH], for himself and Mr. GRASSLEY, proposes an amendment numbered 45 to amendment No. 39.

Mr. HATCH. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To prohibit any Federal matching payment for Medicaid or CHIP coverage of noncitizen children or pregnant women until a State demonstrates that it has enrolled 95 percent of the children eligible for Medicaid or CHIP who reside in the State and whose family income does not exceed 200 percent of the poverty line)

On page 136, between lines 15 and 16, insert the following:

(c) CONDITION FOR FEDERAL MATCHING PAYMENTS.—

(1) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) in paragraph (23), by striking ''or'' after the semicolon;

(B) in paragraph (24)(C), by striking the period and inserting ''; or''; and

(C) by inserting after paragraph (24)(C), the following:

''(25) with respect to amounts expended for medical assistance for an immigrant child or pregnant woman under an election made pursuant to paragraph (4) of subsection (v) for any fiscal year quarter occurring before the first fiscal year quarter for which the State demonstrates to the Secretary (on the basis of the best data reasonably available to the Secretary and in accordance with such techniques for sampling and estimating as the Secretary determines appropriate) that the State has enrolled in the State plan under this title, the State child health plan under title XXI, or under a waiver of either such plan, at least 95 percent of the children who reside in the State, whose family income (as determined without regard to the application of any general exclusion or disregard of a block of income that is not determined by type of expense or type of income (regardless of whether such an exclusion or disregard is permitted under section 1902(r))) does not exceed 200 percent of the poverty line (as defined in section 2110(c)(5)), and who are eligible for medical assistance under the State plan under this title or child health assistance or health benefits coverage under the State child health plan under title XXI.''.

(2) APPLICATION TO CHIP.—Section 2107(e)(1)(E) (42 U.S.C. 1397gg(e)(1)(E)) (as amended by section 503(a)(1)) is amended by striking ''and (17)'' and inserting ''(17), and (25)''.

Mr. HATCH. My amendment simply says that before a State may exercise an option to provide CHIP and Medicare to legal immigrant children and pregnant women, that State must demonstrate to the Secretary of Health and Human Services that 95 percent of its children under 200 percent of the Federal poverty level have been enrolled in either the State's Medicaid program or the CHIP program.

The Secretary may make this determination based on the best data available, and may use any technique necessary for sampling and estimating the number of low-income, uninsured children in that State.

When legal immigrants enter this country, their sponsors agree, the people who bring them in agree, to be responsible for their expenses for the first 5 years they live in the United States.

The CHIP bill contains a provision which was added during the Finance Committee consideration of the bill that negates that agreement by allowing immediate health coverage of legal children and pregnant women. This is the first reason I am offering this amendment.

The second reason is that there are U.S. children who are citizens of this country who are low income and uninsured. They do not have health insurance coverage. They qualify for Medicaid and CHIP too. I believe these children should be our first priority as far as CHIP and Medicaid coverage is concerned. They should be the priority. Once these children have health coverage, then we can talk about expansions to other populations.

I worked very closely with my Democratic colleagues on creating not one but two bipartisan CHIP bills in 2007, CHIPRA I and CHIPRA II.

As I have explained, I voted against my President because I wanted the CHIP program to be reauthorized in the bill we wrote. One of the first agreements that Senator GRASSLEY and I made with Senators BAUCUS and ROCKEFELLER was that legal immigrant children would not be covered under the CHIP program because their sponsors made a commitment to be financially responsible for them for 5 years. That was even before we started drafting CHIPRA I.

I simply cannot support a CHIP bill that allows States to cover legal immigrant children while there are at least 6 million low-income uninsured children, 200 percent of poverty and below, who do not have health coverage and are eligible for CHIP and Medicare.

These children ought to be our first priority. My amendment ensures the majority of these children have health coverage before we expand CHIP and Medicaid eligibility to legal immigrants. I urge my colleagues to support this amendment. It is a reasonable approach. It might have the capacity of helping to bring some of us together in a more bipartisan manner. I hope our colleagues will pay strict attention to some of the things I have said because I believe I have earned the right to be listened to on all aspects of the CHIP bill.

I yield the floor.

The PRESIDING OFFICER (Mr. UDALL of New Mexico). The Senator from Maryland.

Mr. CARDIN. Mr. President, let me compliment my friend, Senator HATCH, for his longstanding work on behalf of the Children's Health Insurance Program. He points out—and rightly so—that this legislation was developed in a bipartisan manner, where Democrats and Republicans worked together to establish a Federal program that allowed our States to use their mechanism to cover children. That is where our difference might be now. We are looking

at reauthorization legislation. We are looking at how we can make this program more effective, covering more children, giving States the tools they need so children can be covered under the CHIP program. The concerns my friend from Utah raises basically would impede on State discretion. We have a national program that is built upon allowing the States to implement and cover children. Each State is different. The priorities among States are certainly different. We need to give the States the tools they need so children actually are covered effectively by this program.

The amendment my friend from Utah has offered would prohibit States from covering legal immigrants and pregnant women. These are, in many cases, people who have been here for a long time, hard-working, tax-paying families, and they are playing according to the rules.

This restriction was imposed in 1996 by Congress. Since that time, many of the restrictions that have been placed upon legal immigrants have been removed. In this instance, what the committee is recommending is to give the States the option of covering legal immigrants without the 5-year wait period. It is not mandating it. It gives all States the option, if they so desire, to cover. Currently, 23 States want to cover these children.

The last time an amendment was offered and we tried to do away with the prohibition on States, our Republican colleagues said: This shouldn't be done as an independent issue. Why don't we take it up when we reauthorize the Children's Health Insurance Program. That is where it should come up. It should not come up on an unrelated bill. That is exactly what we are doing.

This is the reauthorization bill for the Children's Health Insurance Program. This is the time to correct what was done in 1996, in haste, that in many other Federal programs we have already changed. This allows the States to do it.

Many other issues my friend from Utah raised, I assume, will have individual amendments to deal with them. But in most cases, it is the issue of whether we are going to trust our States to run the program. That was the compromise reached between Democrats and Republicans. Quite frankly, there are more people on the Democratic side of the aisle who wanted a stronger Federal presence. But our Republican colleagues said: Let's build upon the State programs. That is what we did in the compromise. That is why the Children's Health Insurance Program has truly been a bipartisan bill.

The bill reported out by the committee is a bipartisan bill. So let me talk for a few minutes about the importance of S. 275, the Children's Health Insurance Program Reauthorization Act of 2009. For millions of children across America who are waiting for the comprehensive health care coverage they need, this week could not have come soon enough. There is a crisis in health care in this country. The United States spends far more per capita than any other nation on health care services. Yet our health status lags in many areas, especially in preventable diseases. This is primarily because we have so many Americans who lack coverage and a fragmented, inefficient health care system that shifts costs onto those who are covered. This is no longer a matter of whether we take action to achieve universal health insurance but how.

We can begin, in the 111th Congress, by guaranteeing children access to the care they need to grow into healthy adults. We can make great strides by reauthorizing CHIP and covering millions of uninsured children now.

Most uninsured Americans belong to working families. It is the CHIP program, first established 12 years ago, that can provide children in these families with affordable health insurance. As a Member of the House, I voted for the bill that created CHIP. At the time, 37 million Americans were uninsured. At the time, I did so with the hope that CHIP would be the first step toward universal health coverage. Although we did not reach the goal then, I believe we are on track to achieve it this year. In the years since, more employers have dropped their coverage. The number of uninsured has increased. Today the number stands at 46 million and growing. I say ''growing'' because today's headlines contain more grim news for our workforce. The New York Times reported a staggering list of companies that announced job cuts on Monday: Caterpillar, 20,000 jobs; Sprint-Nextel, 8,000 jobs; Home Depot, 7,000 jobs; General Motors, 2,000 jobs; Texas Instruments, 3,400 jobs; Philips Electronics, 6,000 jobs.

Over the past year, more than 12.5 million Americans have lost their jobs. Our unemployment rate is now 7.2 percent, the highest in 16 years. As President Obama said yesterday:

> These are not just numbers. These are working men and women whose families have been disrupted and whose dreams have been put on hold.

Whenever we have a family who loses their job, in many cases, they lose their health insurance. If they lose their health insurance, in many cases, they lose their access to quality health care. The numbers are increasing. In many cases, we have two working families. One person loses their job which may cover the family, the other spouse has only single coverage and can't get family coverage or doesn't have the money to afford family coverage. This disrupts a family's ability to take care of their own health care needs. We know CHIP works. Studies have shown and proved that enrollment in CHIP improves the health care of children. When previously uninsured children sign up for CHIP, they are far more likely to get regular primary medical and dental care. They are less likely to visit the emergency room for services that could be rendered in a doctor's office. That saves us health care dollars. They are more likely to receive immunizations and other services they need to stay healthy and lead to healthier schools and communities. They are more likely to get the prescription drugs they need to recover from illness.

The best evidence of the program's success doesn't rest in studies or surveys. It rests in the families themselves. The Bedford family from Baltimore is a success story, one of millions of families in CHIP. Craig and Kim Lee Bedford and their five children have testified on Capitol Hill about the difference the Maryland CHIP program has made in their lives. Mrs. Bedford said:

> Perhaps the greatest impact the Maryland Children's Health Insurance Program has had on our family is that we no longer have to make impossible health choices based on a financial perspective. We no longer have to decide whether a child is really sick enough to warrant a doctor's visit. We no longer have to decide whether a child really needs a certain medication prescribed by his pediatrician.

Mr. Bedford said:

> The face of CHIP is families such as ours, families that work hard, play by the rules, trying to live the American dream.

So for the Bedford family and millions more, CHIP has been a success. But there are still millions of children who have not enrolled in the program offered by their States. Our State is making progress, simplifying their enrollment procedures, expanding outreach efforts and using joint applications for Medicaid and CHIP so families can enroll together. The States are making progress, but as we reauthorize the Children's Health Insurance Program, let's make sure we make real progress.

Our bill will extend the program for 4.5 years and allow an additional 4.1 million children nationwide to enroll. We have to get this bill done.

I wish to talk about the MCHIP program, the Maryland State program. It has one of the highest income eligibility thresholds in the Nation. I know my colleagues have talked about this. This is needed because of the high cost of living in our State. Eligibility is 300 percent of the Federal poverty level, not because our Governor wants to move people from private insurance to public insurance plans. It is at 300 percent because working families at this income level do not have access to affordable health insurance. That is the statistics in my State. Those families need CHIP. This is a State option.

As to one point my friend from Utah mentioned, I don't think the Federal Government should be prescriptive. Allow the States to figure out what program works best. There are incentives to cover low-income families. There are higher matches from the Federal Government, as it should be. We should make sure the lower income families are covered first, and we do under CHIP. Children under the age of 19 may be eligible for MCHIP, if their

family income is at or below 200 percent of the Federal poverty level or up to $34,000 for a family of three. Our program has been a true success. Enrollment has grown from about 38,000 enrollees in 1999 to more than 100,000 today. In Maryland, the need has always exceeded available funds. We actually spend more money than the Federal Government will give us. The Federal match through the CHIP formula established in 1997 is not enough to meet all the costs of the MCHIP program. Some States do not use their entire allotment, while other States, such as Maryland, have expenditures that exceed their allotment. Congress has addressed this problem by redistributing the excesses of the States that have them to States that have shortfalls. Now we must move forward for future years.

This is what we are doing on the floor of the Senate today. I thank Chairman BAUCUS and Senator ROCKEFELLER for their efforts on this bill. This bill will allow us to continue to cover children and families with incomes up to 300 percent of poverty. Maryland would also have access to contingent funds, if a shortfall arises, and additional funds based on enrollment gains. With this new money, Maryland can cover an estimated 42,800 children who are currently uninsured over the next 5 years.

There is another important part of this bill I wish to talk about for a moment, section 501. It hasn't gotten much attention, but it certainly has received a lot of attention around the country. Section 501 ensures that dental care is a guaranteed benefit under CHIP. I agree with my friend from Utah, we need to set standards at the national level. Dental benefits must be included. According to the American Academy of Pediatric Dentistry, dental decay is the most common chronic childhood disease among children. It affects 1 in 5 children between the ages of 2 and 4 and half of those between the ages of 6 and 8. Children living in poverty suffer twice as much tooth decay as middle- and upper-income children. Nearly 40 percent of Black children have untreated tooth decay in their permanent teeth. More than 10 percent of the Nation's rural population has never visited a dentist. More than 25 million people live in areas that lack adequate dental services.

Next month will mark 2 years since a young man from suburban Maryland named Deamonte Driver passed away. He was 12 years old, when he died in February of 2007 from an untreated tooth abscess. His mother tried to access the system, tried to get him to a dentist. What was needed was an $80 tooth extraction. Because of the failure of the system to cover his services, an inability to get to a dentist, Deamonte ended up in an emergency room. A quarter of a million dollars was spent in emergency surgeries. He lost his life in the United States in 2007.

This bill will do something about it by covering oral health care, as it should. Deamonte's death has shown us that, as C. Everett Koop once said, ''There is no health without oral health.'' No children should ever go without dental care. I have said before, I hoped that Deamonte Driver's death will serve as a wake-up call for Congress. Section 501 of this bill shows that it has. We must never forget that behind all the data about enrollment and behind every CBO estimate, there are real children who need care.

When I spoke about Deamonte Driver after his death, I urged my colleagues to ensure that the CHIP reauthorization bill we send to the President includes guaranteed dental coverage. This bill does include guaranteed dental coverage. It also provides ways in which families will have a better understanding of the need for oral health care. It also provides ways in which families can access dentists who will treat them under either the CHIP program or the Medicaid Program.

This legislation is a major step forward on dental care. We need to do more. I want to acknowledge the work particularly of Senators BINGAMAN and SNOWE on oral health care. They have been real champions in this body in moving forward on these types of legislation.

This bill will also require GAO to study and report on access to dental services by children in underserved areas, access to oral health care through Medicaid and CHIP, and how we can use midlevel dental health providers in coordination with dentists to improve access to dental care for children. The results of this study will give us the information we need to further improve coverage.

We still have to raise reimbursement for dental providers, and send grants to the States to allow them to offer wraparound coverage for those who have basic health insurance but no dental insurance. But these provisions are an excellent start.

After two vetoes of a bipartisan CHIP bill by the former President, I am so pleased to stand here today on the floor of the Senate and express my strong support for S. 275. This is the week in which we can make progress in covering people in this country, particularly our children, with health insurance. One week after the inauguration of President Obama, we are poised to move this bill through the Congress and to his desk so it can finally become law.

I urge all my colleagues to vote in favor of this legislation, as we start down the path to universal health coverage for all Americans.

With that, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from South Carolina.

AMENDMENT NO. 43 TO AMENDMENT NO. 39

Mr. DEMINT. Mr. President, I ask unanimous consent that the pending amendment be set aside, and I call up amendments Nos. 42, 43, and 44, and ask for their immediate consideration.

The PRESIDING OFFICER. Is there objection?

Mr. CARDIN. Mr. President, I do object. The reason, quite frankly, is that we have worked out with the Republican leader that we would have three amendments pending. We have those three amendments pending. I think it is important we have an opportunity to act on those three amendments. We certainly look forward to other opportunities where my colleague will be able to offer the amendment, but at this point I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from South Carolina retains the floor.

Mr. DEMINT. Thank you, Mr. President. I do not intend to speak on them, so we would not use any time. I think it is important we have amendments pending so our colleagues will have ample time to review them.

I would ask the Senator to reconsider. Again, I am not going to speak on them. I only want them pending so we can distribute them and people can begin to see what is in them.

Mr. CARDIN. Mr. President, if my colleague will yield?

Mr. DEMINT. Yes.

Mr. CARDIN. We would be pleased to allow the Senator to call up amendment No. 43 but not the entire list of amendments the Senator sought.

Mr. DEMINT. I appreciate the benevolence, and I would hope the Senator would agree that all of these amendments at some point can be made pending in the debate.

But I will call up only amendment No. 43 right now.

Mr. CARDIN. To point out to my friend, we already have three amendments that are pending, and we are hoping to make progress, and we want to get votes on these amendments. I will not raise an objection to setting aside the amendment for the sole purpose of offering amendment No. 43.

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

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from South Carolina [Mr. DEMINT] proposes an amendment numbered 43 to amendment No. 39.

Mr. DEMINT. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To require States to impose cost-sharing for any individual enrolled in a State child health plan whose income exceeds 200 percent of the poverty line)

At the appropriate place, add the following:

SEC. ___. REQUIRED COST-SHARING FOR HIGHER INCOME INDIVIDUALS.

Section 2103(e) (42 U.S.C. 1397cc(e)) is amended—

(1) in paragraph (3)(B), by striking ''and (2)'' and inserting '', (2), and (5)'';

(2) in paragraph (4), by striking ''Nothing'' and inserting ''Except as provided in paragraph (5), nothing''; and

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

''(5) REQUIRED COST-SHARING FOR HIGHER INCOME INDIVIDUALS.—Subject to paragraphs (1)(B) and (2), a State child health plan shall impose premiums, deductibles, coinsurance, and other cost-sharing (regardless of whether such plan is implemented under this title, title XIX, or both) for any targeted low-income child or other individual enrolled in the plan whose family income exceeds 200 percent of the poverty line in a manner that is consistent with the authority and limitations for imposing cost-sharing under section 1916A.''.

The PRESIDING OFFICER. The Senator from South Carolina is recognized.

Mr. DEMINT. Thank you, Mr. President.

Obviously, I am disappointed in the process. It is important we let our colleagues know what amendments will be offered so we can begin to discuss them; and many times we have the opportunity to work these things out, improve them before debate. Unfortunately, many times in the past we have seen where the majority pushes the bringing up of these amendments to the very end and then says we do not have time to debate them. I hope that will not occur this time.

I have three good amendments. The one I just brought up I will not speak on at this point but will mention the subject of that amendment. It is a cost-sharing arrangement with the States that for all recipients of SCHIP over 200 percent of poverty the States are required to ask for some small cost-sharing with people who use this insurance. It is important that we look at this as a program that, hopefully, will move people from a Government-sponsored plan to eventually a private plan, with our goal being every American is eventually insured with a policy they can own and afford and keep.

So this would work with the States to require a small cost-sharing arrangement with the beneficiaries who are 200 percent of poverty or more, and it would not be more than 5 percent of income, and States can charge as little as they would like. But the whole point is to begin to encourage personal responsibility and to let people know this is not a permanent giveaway but something they need to participate in.

I look forward to discussing this amendment in more detail along with my other amendments sometime in the future. But right now, Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. CASEY. Mr. President, I rise at this moment to review, in a summary form, pertinent aspects of the legislation. I know we are going to be having a debate on various parts of this bill that have been the subject of a lot of conflict in the last couple of days. But I think it is very important we kind of get back to the basics to talk about why we are here.

We are not here to only debate several provisions of this legislation. We are here to debate, in a larger sense, whether we are going to pass a children's health insurance bill this year, this month, or not. That is the fundamental debate we are having. We had the opportunity, in 2007, in a bipartisan way, here in the Senate to achieve a rare and, frankly, unprecedented bipartisan agreement on a significant piece of legislation, the result of which would have been, over a 5-year period of time, to insure 10 million American children.

I am not sure any other generation of Americans has had that opportunity. We had a bipartisan consensus in the Senate. It approached 70 votes—in the high sixties—every time it was voted on; a veto-proof number of votes, a majority. It went to the House, of course. The House debated it, and they had an overwhelming bipartisan vote in the House. It went to President Bush, and he vetoed it twice. Then it came back for an override, and we were able to override it in the Senate, but in the House they fell short. That is where we are. So because of the actions of President Bush, that bill never became law.

Now we are back to debating whether this Congress is going to provide health insurance to not just 10 million—it is now 10.6 million—American children. We are either going to do it or we are not. All this other stuff is interesting to debate, and we will continue to debate it, but we are either going to do it or we are not.

Let me give you one example of what this means. Forget all the numbers for a second and all the programs and all the quibbling about some point of conflict. We will address those issues today, and I will as well. But let's get back to the basics: what this legislation means to a family.

For example, as a result of this legislation, if we do our job here and get this legislation passed, and if the House does its job and passes this legislation, millions of American children will have the opportunity for all kinds of good health care provisions, a lot of them preventive in nature.

We have a lot of discussions in this body where people talk about the workforce and growing the economy and building a stronger skilled workforce in the future. None of that means much unless you are going to do this, OK. A child will not develop, they will not achieve in school, and they will not be productive members of our workforce unless we pass legislation such as the children's health insurance bill.

I will give you one example: well-child visits. Anyone who knows anything about child development—I do not consider myself in any way an expert on this issue; others may—but we all know, as parents—forget legislators or experts—it is as parents we know how important it is to have a child go to the doctor a couple times, at a minimum, several times in their first year of life. It is a key time for parent and physician to communicate. Doctors recommend six visits in the first year of a child's life.

Now, with this legislation we have an opportunity to guarantee that millions more children will see a doctor six times in their first year of life. That is something we ought to do.

They get a complete physical exam. Height, weight, and other developmental milestones are mentioned. Hearing and vision are checked. Important topics, such as normal development, nutrition, sleep, safety, infectious diseases, and all kinds of other issues, are discussed; general preventive care.

Now, if we allow some of these discussions and debates today to bog this down and not get it passed in a bipartisan way, what we are preventing is, among other things, millions of children getting this care. It is as simple as that. So those who are going to use these other things to put them in the way as impediments or obstacles, to block this legislation, should be reminded and the American people should be reminded what they are stopping. This is not complicated. It is whether millions of children are going to have health insurance; and one aspect of that care or that health insurance is a well-child visit.

The other point I want to make in the early going today is there is a good bit of mythology that surrounds this legislation, and sometimes facts are not put on the table. This is mostly a question of whether working families are going to have health insurance. There is a frustration now that so many families are living with the loss of a job, the loss of a home, the loss of their livelihood and, therefore, their hopes and their dreams.

The least the Senate should do, in the midst of what is arguably the worst economic circumstance in more than a generation—maybe the worst economy we have faced since the 1930s; we can debate all that, but it is bad out there, it is real bad for families—the least we could do is to say, we may not have solved the larger health care challenge, we may not have fully debated all the aspects of health care we are going to debate and I hope we can vote on, but at least we can take an existing program that we know works, that is battle tested, that has results for 15 years now—my home State of Pennsylvania; when my father served as Governor, he signed this into law, which was the first big State to do it. He knew it worked. He knew it worked then, and he supported it strongly. It has worked in Pennsylvania. We have over 180,000 kids covered. This legislation would increase that to the point we could almost cover every child in the State, for example.

But in the midst of this economy, the least the Senate should do is say: We may not have solved all of our economic trouble, we may not have even solved significant aspects of our health care challenge, but the minimum—the minimum—this Senate and this Congress and this administration should do is get this done, and get it done now.

All these other debates are interesting and important, but, frankly, some of them are academic in nature. I know they have risen to the level of conflict, and I know the media likes to report on conflict. That is their job. But a lot of them, compared to the gravity of what is at stake here, are academic, in my judgment. And I think for some—not everyone but for some—they are deliberately calculated to stop this legislation, deliberately so. I hate to say that, but it is the way I feel. We are getting down to the details now of getting this done, and we have to be blunt and direct.

So we are going to have debates about parts of this legislation, but at the end of the day the question is whether the Senate is going to provide millions more children with health care. That is the question. All this other stuff does not amount to or does not rise to that level. They may be important debates, but they do not rise to that level.

One more point, and I will yield because I know we have colleagues waiting.

Seventy-eight percent of children covered by CHIP are from working families—working families. I will get into some of the other aspects as well. But at this time I will yield the floor because I know we have colleagues waiting.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, I wish to ask the Senator from Pennsylvania a couple questions, if he might be so kind as to respond.

Your earlier statement was without this, children will not develop, children will not become productive members of our society.

Having taken care of 4,000 infants and done well child exams on them, what is the number of children out there who are not getting vision and hearing screens right now?

Mr. CASEY. Well, I don't have a number on them.

Mr. COBURN. The number is zero because every one of them is tested.

Mr. CASEY. Let me finish.

Mr. COBURN. I control the time.

Mr. CASEY. Let me finish the answer. If we do not pass this—if we don't pass this, those children won't get that preventive care. It is as simple as that.

Mr. COBURN. That is simply not true.

Mr. CASEY. How are they going to get preventive care?

Mr. COBURN. They are going to get preventive care, and let me tell my colleagues how. What is the number of children who are not getting preventive care in the first 6 months of life right now? We don't know that number, and that is exactly the problem.

Here is the point: Every one of us wants children to get health care. It is not about wanting children to get health care.

Mr. CASEY. This is the way to do it.

Mr. COBURN. The fact is, we have an SCHIP program now and a Medicaid Program right now where we have 5.4 million kids who are eligible and who are not enrolled.

What we are doing is exactly the opposite of what President Obama stated we should be doing. He stated that we should be being responsible. I would contend that one of the areas of being responsible is to make sure programs work. When we have a program where last year, on average, 5.5 million kids were covered and another 5.4 million kids who were eligible weren't covered, I would tell my colleagues that program isn't working very well. It is not working. So what have we done? We have expanded the eligibility with this bill.

The debate over how we cover all the rest of Americans—we will have that debate, and I am sure we are going to have that debate this year. But the fact that 51 percent of the eligible children under the programs we have now, under the requirements we have now, are covered means 49 percent aren't. In this bill is a measly little $100 million to try to expand the enrollment of those kids who are already eligible.

I would think the average American out there who does have insurance or who may not have insurance might say: Well, why don't you make the program you have today work? We would have more kids covered than this bill will totally cover if we just made the requirements that the States and Medicaid directors throughout do the outreach to get the kids who are eligible.

The fact is, most of the poor women in this country—up to 300 percent right now—deliver under either title XIX or Medicaid. Their children are covered the first year of life. They are not going to miss the first well child visit. As a matter of fact, they are the ones—the biggest problem we have is getting the people who have coverage to be responsible and to bring their kids in. It is not about coverage; it is about responsibility—the very thing our new President said we need to reach up to and grab.

The other point that has to be brought forward in this debate is there is a lack of integrity with this bill. Let me tell my colleagues what it is. I do not doubt this Senator's integrity whatsoever. He is a friend of mine. When he speaks, he speaks from the heart. But when we manipulate the numbers and we drop a program from $13 billion to $8 billion in the last year of the first 5 years of its authorization so we don't have to meet the requirements of living within our means, and then we transfer $13.2 billion so we lower the baseline—this is all inside baseball—what, in fact, we are doing is we are lying to the American people to the tune of $41.3 billion. That is what CBO says. That is what CBO says in a letter to PAUL RYAN, the ranking member on the Budget Committee in the House, that, in fact, because we manipulated the numbers, because we cheated with the numbers, that it is actually going to cost $41.2 billion or $41.3 billion more than what we are saying it is going to cost.

Why is that important? Because we have decided to pay for this with one of the most regressive taxes toward poor people that we can. The consequence is that we are going to tax them and then we are going to wink and nod to the rest of the American public to say: This $41.2 billion, oh, don't worry about it; we are going to fudge the rules; we are not going to play the game honestly and with integrity. There is not going to be change you can believe in because the Senate's bill winks and nods at $41 billion. We all know that is there. We all know that is the only way they can do it to where it is scored in terms of pay-go.

So what we did is we paid attention to the numbers but not to the integrity behind the numbers. So the American taxpayer in some way or another will take on, from 2014 to 2019, an additional $41 billion. That is not change, folks, regardless of how good our goal is, regardless that every Member of this body wants to see kids who don't have care covered. Every Member wants to see that. We don't want the first child, we want every American covered—every American covered. But to do that under the guise of ''integrity in our numbers'' puts us right back into the same problems that got us into the deep financial problems we have today.

Let's be honest. Let's talk about what this bill really costs, what we know it would cost if we didn't play a game with the numbers, and what we could do to offset some of the programs President Obama says need to be eliminated so we can do the things that are good. There is not one attempt in this bill to do that. As a matter of fact, there is an attempt to cover non-U.S. citizens at the expense of U.S. citizens in this bill.

So basically we are going to keep a 9-percent approval rating because we are not going to earn the trust of the American people about being honest about what something really costs. I want to tell my colleagues, that undermines the whole debate. It sends us on a track to where we are going to be a Third World country because we won't even be honest about what things really cost. There is nothing wrong with having an honest debate about what this bill really costs, but to deceive the American people on what this bill actually costs—actually costs and will actually cost them—it is not going to cost us; it is going to actually cost them. It is going to cost them in terms of a lower standard of living and less opportunity.

Let's get honest about what it really costs, and it really costs $41.2 billion more than what we say it is going to cost. Let's do the hard work. If the bill is such that the Senator from Pennsylvania thinks it is absolutely necessary so children will develop, so children will become productive, isn't it worth getting rid of things that don't make

kids develop and don't make them productive? Isn't it worth us taking the heat to get rid of programs that aren't effective so we can actually pay for this? Instead, we are in essence lying to the American public about the true cost of this bill. That is what has to stop.

The integrity of those who want to do this is fine. The integrity of the numbers stinks. For us to say we are for children and have that honorable position that we are for children, but at the same time we want to undermine the faith in this place so they can't believe us in the future because we are going to charge them $41.2 billion more than it actually costs says a whole lot about us.

Every child should have an opportunity for health care. Every child should have prevention. Every child should get a hearing screen and a vision screen as we do now at every newborn nursery in this country. Every child should get their immunizations at every opportunity when they encounter—first at 2 months, 3 months, 6 months, 9 months, and a year, their first year of life. The whole purpose for that screening is to see if development is not normal.

The Senator from Maryland talked about the mandated oral health care in this bill. The mandated oral health care in this bill is a direct consequence of one of our other programs to help people. It is called food stamps. When we look at the mix of food stamps, what do we see? We see a high predilection for high-fructose corn syrup in the foods that we use food stamps to buy which causes the very dental caries we are fighting. So do we fix the real problem or do we treat the symptoms? We ought to be about fixing the real problems. So if we want to do and mandate oral health care in this bill, why don't we put a limitation on the high-fructose corn syrup products and high-glucose products that are the No. 1 cause of the dental caries the kids are having? An ounce of prevention is worth a pound of cure. But we didn't do that.

We didn't come forward with a total plan on health care, which is the whole problem as we try to expand this bill to meet a need. What we need to do—and I think the Senator from Pennsylvania agrees—is we need to reform all of health care. It needs to be based on prevention. It needs to be based on prevention. It needs to be based on teaching and preventing disease rather than treating disease.

My hope is that when we come through this, whatever we do, win or lose—whether my side wins or the other side wins—what should happen is Americans should win. The American people should win. What that means is an honest debate about the numbers—not a game with the numbers, an honest debate about the numbers—and what it really means is an honest debate about what the real problems are and not about things that aren't the real problems.

We have plenty of money in health care. We don't need to increase spending in health care. What we need to do is redirect the spending that is there. We spent $2.28 trillion last year on health care. Thirty percent of that money didn't go to help anybody get well or prevent anybody from getting sick. That is $600 billion. If we would look at it and say prevention is going to be No. 1, and No. 2 is going to be every American insured, we could go a long way toward solving this problem.

Unfortunately, however, we have chosen to start off the new SCHIP by trying to pull the wool over the eyes of the American taxpayer, by playing funny numbers. Why would we leave that out there? Why would we do that? It lessens the integrity of the debate. It lessens the quality of the work product we put forward. It undermines the very thing we need most from the American people, which is their confidence that we are doing what is in the best long-term interests of the country. This bill isn't in the best long-term interests of the country. The bill doesn't address the needs of the Medicaid populations out there today who aren't served who could be served if, in fact, we should mandate that the States go and do it. But we have chosen not to do that. We have chosen to expand up the chain before we fix the problems down the chain. We have chosen to take dollars and give them to those who are more fortunate instead of spending dollars on the people who are the least fortunate in this country, all in the name of a movement to close in ultimately on a single-payer health system. Let's have the debate about single-payer health system.

One final point I will make before I yield to my friend from North Carolina, and that is this: The most important thing after access is choice. We know what. Medicaid offers little choice. SCHIP offers little choice. The reason is because we have a payment system that rewards specialty and doesn't reward primary care. It started with Medicare, and it has worked its way through Medicaid. So our average pediatrician in this country makes about a fourth of what the average surgeon does or about a fourth of what the average gastroenterologist makes, and we ask ourselves: Why can't we get more pediatricians? Our average family practitioner makes a little bit more than that, but not much, and we ask ourselves: Why can't we get people out there into primary care? Our average internist makes just a little bit more but still about a fourth of what the specialists make because we have decided to pay it. Who is going to take care of them? Let me tell you who is going to take care of them: PAs and nurse practitioners. Some are excellent, some are great, but none of them have the training of a physician. We are slowly walking to a health care area where we are going to tell people you have coverage, but the coverage is you do not have choice and you do not have the same level of care because we have not chosen the priorities of compensating primary care, compensating pediatricians, compensating pediatric dentistry, compensating internists to care for these kids.

Choice is the most important thing, and the reason is because if a mother is taking her child to a health care professional in which she does not have confidence, do you know what happens? She does do what they say.

As we eliminate choice, which is what happens in SCHIP and Medicaid because so few physicians take it because the reimbursement rate is so low, we eliminate the doctor-patient relationship in establishing the confidence necessary to make sure, as the Senator from Pennsylvania said, that these kids will develop, that they will become productive.

The idea behind this whole program is we have taken away the most important attribute of consequences of care, and that is confidence in the provider.

I yield to my colleague from North Carolina.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. CASEY. Mr. President, I know our colleague from North Carolina has been waiting. I wish to make a couple brief points and come back to them. Our colleague has been waiting.

The Senator from Oklahoma makes a number of interesting points. Some of them are going to be the subject of even more debate. I will make a couple brief points about the question of enrollment and, therefore, outreach.

One of the biggest problems with the veto and the blockage of the children's health insurance legislation in 2007 was we did not have the resources to do the kind of outreach, to enroll those who are eligible but not enrolled. We would have gotten as many as 3.3 million more eligible kids had the 2007 bill not been blocked. Point No. 1 on outreach.

This bill, in fact, has steps to improve enrollment. In fact, it provides bonuses if States do a better job of enrolling children. We will get back to that in a moment.

The point about single payer that the Senator made, we are going to have a lot of debate about philosophy on health care overall and where this whole health care debate is going to go. That statement is premature or unrelated to what we are doing today.

What we are doing today is talking about whether we are going to pass the children's health insurance bill, not some new program but a program that has been tested. We want to add millions more children to that program.

The final point—and I know our colleague has been waiting—is the question of choice. The Senator from Oklahoma made a point about what choices people will have if they are enrolled, if families are enrolled in SCHIP, Medicaid or any other program of its kind. The problem for a lot of families right now is not that they are lacking in choice of options; the problem for a lot

of families, if their children are not enrolled, is they have no choice, they have no health insurance at all, except if they want to go to the emergency room, which is bad for the economy and bad for that family because it is usually too late in the game, so to speak, to get the kind of preventive care or to mitigate a problem.

For a lot of families right now, this is not a question of choices. They have no choice because they have no health insurance. I will come back to this point, but I wish to yield for my colleague from North Carolina.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I thank my colleague from Pennsylvania. I do not wish to dwell on what he said, but let me make this point. He said we are not here to talk about the bigger health care piece. From the standpoint of the bill, he is exactly right. This is another attempt to grow the size of a Federal Government program to include more Americans in it without taking on the tough task of debating how we fix health care in this country; and what are the reforms that have to take place so every American has the opportunity to be insured.

Let me cite some facts about the Baucus bill. The Baucus bill spends $34 billion over 5 years. Actually, it might spend more than that based on CBO. It increases the number of enrollees in SCHIP by 5.7 million children. By the way, 2 million of those children are currently covered under their parents' insurance. Let me say that again. We are spending $34 billion over 5 years to increase enrollment in SCHIP by 5.7 million children, and 2 million of them are already covered under their parents' health care insurance.

When our benefit gets bigger, when it becomes even more inclusive, what happens? We say to the American people: Why should you pay for it? We have a government program to cover your children instead.

There is an alternative, and it has already been offered in one of the first three amendments. It is the McConnell amendment, Kids First. It spends $19.3 billion over the same 5 years. It enrolls 3.1 million new kids. For $19.3 billion, we get 3.1 million kids, and for $34 billion over 5 years, we only get 3.7 million new kids when you consider the 2 million that are already insured. The American taxpayers ought to ask us: For the additional 600,000 kids who are uninsured today whom we would be pulling in under the Baucus bill, what does it cost them per child? The answer is $4,000.

Having just had a son who reached an age in college that he can no longer be under my insurance, I was amazed when I tried to get this college senior insurance. Naturally, I turned to the Federal Government I work for and said: Surely you have a plan already in place for my child and the other 2 million Government workers who might fall into this classification.

They said: We certainly do. We have negotiated with the same insurance company for the same coverage that your son was under when he was covered by you.

What is the annual cost of that? I said to the Office of Personnel Management.

They said: $5,400 a year. Mr. President, $5,400 a year. The Government negotiated for my 22-year-old, healthy-as-a-bull son to be covered under the same insurance plan he had before.

What did I do? I picked up the phone. I called the university. I said: Surely you have plans for kids whose insurance runs out. They said: We certainly do. We have it with this company, it is this plan. It was the exact same coverage I had as a Federal employee. I asked the magical question I would ask anybody: How much does it cost per year? The answer: $1,500. One phone call and I saved $3,000 for a 22-year-old, healthy-as-a-bull college senior because I no longer let the Federal Government be a part of his health care decisions. I took him out. For $1,500, my son was covered. For every year under that 22 years of age, an amazing thing happens. Children get cheaper to cover. They get cheaper to cover because they are less likely to have serious illnesses.

The most likely period of illness for somebody under 18 is what Dr. COBURN referred to, the first year of life. That is why we make sure that in that first year of life, every kid gets the exams they need to make sure they are on the path to not only a successful life but a healthy life.

One should not be amazed to find out that the average cost for insuring someone under 18 years old is about $1,200 a year for full health coverage, compared to $4,000 under the Baucus bill. But what are we debating here today? This was the part, from my colleague's earlier statement: If we allow discussions and debates to bog us down, then this is a huge mistake. That is what he said.

We are having a discussion and a debate about what the American taxpayers are willing to pay for a benefit. We all agree the SCHIP program should be expanded. But some of us believe we ought to have the bigger debate now about how we fix the American health care system. How do we walk away from the Senate Chamber confident that every American has the opportunity to have a health insurance policy?

But, no, we have decided not to do that. We have decided to take one little piece—kids. Why? Because every American wants to do something for children. I want to do it. But I am also inclined to do the right thing for kids, not just anything for kids.

It was said earlier that this was a bipartisan bill. Let me point out for my colleagues and for those paying attention to this debate, when this legislation passed the Finance Committee, it got one Republican vote. I am not sure that is the bipartisan measurement tool President Obama said he needed when he was sworn in as our 44th President. As a matter of fact, he is aggressively coming to the Hill in about 1 hour to meet with Republicans to talk about the stimulus package because he does not want a stimulus package to just barely pass. He wants overwhelming bipartisan support. But bipartisan support was just defined here as when one Republican votes with every Democrat to pass a bill.

An amazing thing, if you look back to 2007—excuse me, 2008, I think it was—when a bipartisan SCHIP bill did come out of the Finance Committee. The ranking member voted for it, and the second highest ranking Republican in seniority voted for it. They came to the floor and spoke on it. Chairman BAUCUS—it was his bill. There was bipartisan support. So, what happened this year? Why didn't we start with the bipartisan bill we had last year? They took everything Senator GRASSLEY, everything Senator HATCH incorporated into the bipartisan bill, and they ran right over them. They threw it out. If you see something on the floor in the Senate today, it is road kill. That is where Senator GRASSLEY and Senator HATCH were thrown aside. Not in an effort to reach bipartisanship, but in an effort to be prescriptive as to exactly what SCHIP said and who it covered.

Make no mistake about it, when Senator CHUCK GRASSLEY comes to the floor—and every Senator in this Chamber understands it—and says that when you strike the 5-year waiting period before legal immigrants can get benefits, you have now opened the insurance program to new legal immigrants to America who have a responsibility, which is accepted by their sponsor, to make sure they do not accept Federal Government benefits. In other words, they are not at the taxpayer trough for at least 5 years.

What did we do with that important legal safeguard in this bill? We discarded it. We said: No, we will let you at the taxpayer trough. We will let you there on day one, even though when you came into the country you and your sponsor said: I will not do that for 5 years.

Not only did we do that, we actually threw away the verification that they are legal. We no longer under SCHIP will require a photo ID of somebody who walks in to be enrolled in SCHIP. All we say is you have to have a name and you have to have a Social Security number, one of which can be made up, the other of which can be bought. It is an amazing thing. We see it every day.

We have had every sort of immigration debate on this Senate floor. We are building a wall along the border today because there is an immigration problem. Yet we have now said: You know what, let's forget about that part about sponsorship when you come to this country legally. Let's forget about the obligation that your sponsor had to make sure that for 5 years they were there for the financial assistance you

needed. And, oh, by the way, in case there are folks out there who might not be here legally, let's not require them to show a photo ID to make sure the person who is in line matches the name they gave us and matches the Social Security number that was provided.

What we have done is we have opened a tremendous loophole. I am all for making sure, as I said earlier and Dr. COBURN has said, we want to make sure every American has health insurance. I am not trying to cut anybody out.

But if we want to target those people who are here legally for under 5 years, or those people, for heavens' sake, who are here illegally, then we should integrate them into a health care system that works.

Today, cost shifting alone in the American health care system costs $200 billion a year. If we are talking about having a debate on health care, let's talk about how to eliminate that $200 billion that doesn't go to prevention, doesn't go to wellness, doesn't go to insurance coverage. It goes to a big black hole that doesn't deliver health care to any American.

As I stated, this is not a debate about health care reform. It is a debate about growing a Federal Government program.

The SCHIP statistics: 7.4 million children were enrolled in SCHIP in 2008, a 4-percent increase over 2007. Yet, if you look at the devil in the details, there were only 5.5 million enrolled on average per month; 7.4 million total enrolled, 5.5 million on average throughout the year. And 5.4 million additional people are eligible for Medicaid or for SCHIP in this country and are not enrolled. Exactly what Dr. COBURN said earlier to my good friend from Pennsylvania. We have 5.4 million children who, today, are eligible for Medicaid or for SCHIP but are not enrolled.

I remember when Dr. COBURN and I held up the President's PEPFAR bill, when we were talking about an increase in funding from $15 billion to $50 billion for AIDS treatment in Africa. There was only one thing, when they increased substantially this amount of money for the program, they also dropped the requirement that 50 percent of the funds actually be used to treat people living with AIDS or HIV disease. They said we would leave that up to the NGOs implementing the program.

In other words, the NGOs said: To get any further into the population of people who have HIV and AIDS, that is going to be really tough. Rather than attempt to do something tough, we were going to lift the requirement that 50 percent of the money had to be spent on medical treatment.

So, what are we doing here? Now we have gotten to the SCHIP population that is tough—5.4 million kids who are eligible for Medicaid, eligible for SCHIP but are not enrolled. What are we saying? OK, States, we know it is tough to get to that 5.4 million kids so we are going to allow you to expand the pool you are able to solicit for this program. We are going to increase the percentage of Federal poverty that you are going to be able to include in this program—and I might say this to my good friend Senator BEN CARDIN, who served in the House with me, not only did I vote for this program, I helped craft the first SCHIP bill. I remember the laborious days when we sat trying to figure out exactly how to structure it, a program that was designed for States to run, for us to target those kids in America whose families did not have enough income to afford health care for them but had too much income to be eligible for Medicaid. It was targeted specifically at the families who were over 100 percent of the Federal poverty level but under 200 percent of the Federal poverty level.

That may be Greek to a lot of folks, so let me point out: At 200 percent of the Federal poverty level for a family of four, a person earns $44,000. Now we are up to 300 percent of poverty in SCHIP and 300 percent of poverty is $66,000 a year. But there is an exception, because New Jersey currently has a waiver to go up to 350 percent of the Federal poverty level in SCHIP. That puts them at $77,175, for a family of four.

What about the Baucus bill? The Baucus bill also allows, for New Jersey and New York, the ability to go up to 400 percent of poverty—$88,200 a year for a family of four.

For God's sake, do not lecture me on what SCHIP was designed to try to do in this country. We are leaving 5.4 million kids behind today who currently are eligible, and then you tell me there is some rational reason why we should roll over and pass something without a debate that increases the eligibility from where I had it targeted at $44,000 a year and raise it up to $88,200 a year. Why do others think we need to increase the eligibility? It is simple. Because it is too hard to reach the 5.4 million children who are below 200 percent or 300 percent of poverty who are eligible but not enrolled today in this country.

On another topic, the Medicaid FMAP in this country ranges from 50 percent to 75.9 percent with a ceiling of 83 percent, meaning that is how much the Federal Government gives to the States for our portion of their Medicaid payment. SCHIP offers a higher Federal match than Medicaid. The SCHIP match ranges from 65 to 83.1 with a ceiling of 85 percent.

If you listened to me list the numbers, I think you can figure out what is going on, on the Senate floor today. Why do some want to increase the eligibility limits? It is because, for some States under Medicaid, they get a 50-percent match, but under SCHIP they get a 65-percent match. So, you want to expand SCHIP eligibility because then the Federal Government is picking up 15 percent more of the tab. Why wouldn't some want the parameters of SCHIP to increase if we are letting the State off the hook for 15 percent of the cost they are obligated to cover?

As a matter of fact, in full disclosure, let me say that in North Carolina our SCHIP match rate is 74.8 percent, and our North Carolina Medicaid match rate is 64.6 percent.

I think it is important also to remind my colleagues that in the Baucus bill, even though it limits the SCHIP match rate to children and families below 300 percent of poverty, it still does allow Medicaid to, in fact, wrap around that. I call it the Medicaid sandwich. Medicaid covers people up to 100 percent of poverty, SCHIP fills in right here, and then Medicaid goes back right on top.

I am not sure there is a rational, sane person in the world who would design the health care system we currently have. Yet we are on the Senate floor today, and we will be here tomorrow and the next day and we will probably be here the entire week, and we are here trying to rationalize why this program needs to be reauthorized in its current form, why we should drop things that have been bipartisan in the past so we can increase the enrollment size to include somebody here legally but under sponsorship, or people here illegally but who want to be covered. We are here to debate whether the eligibility parameters should be increased.

I return to my colleague from Pennsylvania, to another one of his quotes. He said ''all this stuff doesn't rise to the level.'' Well, I believe it does. Everybody is entitled to their opinion. But I believe this stuff does rise to the level of Senate debate. I believe it rises to the level of public disclosure.

The American people look at SCHIP. And I might note, Mr. President, we had this debate last year as we got ready for reauthorization, when all of a sudden SCHIP dropped the ''S.'' I noticed, with the first two speakers on the majority side today, that everything refers to the CHIP program. I assume I have not picked up the provision in this bill yet that eliminates this as a ''State'' program, and now it is going to be only the ''Children's Health Insurance Program,'' run by the Federal Government, administered by the Federal Government, and the States will not have anything to do with it.

I haven't found that provision yet but, then again, we have not had the bill long enough to read all the nuances of it. We have had it long enough to read the budget aspects of it, and I think Dr. COBURN alluded to that very effectively.

CBO says the Baucus bill spends, in fiscal year 2012, $14.98 billion. Rather than continue that spending level for SCHIP into 2013, the bill somehow drastically reduces the allocation to only $5.7 billion in 2013.

Let me cover that again. In 2012, we allocate $14.98 billion for SCHIP, almost $15 billion. But under the bill's

structure in 2013, we allocate only $5.7 billion for the health care of that same population. Somehow we are either going to lose two-thirds of the kids under the program or we are miraculously going to find another $9 billion.

You know, numbers like $9 billion appear frequently up here. It is called debt. It is called debt on our children and our grandchildren. We make it up, we print it, we fund it, it goes into place.

I might add, I am not sure I am the only one who caught onto this. I think Senator BAUCUS caught onto it too when he wrote the bill because in 2013 he also has a one-time charge of $11.4 billion, not counting the 2013 allocation. I was worried that I might not have read the numbers right the first time until I looked at 2013 and I found the one-time charge.

He just doesn't want that amount included as a score under the 5-year timeline. Why? Because as Dr. COBURN said, we are being less than honest with the American taxpayer. We are suggesting that this program can be run for X and we know it is going to cost Y. How in the world can we take something up as serious as children's health insurance and lie about the numbers? If we lie about the numbers, how do we expect the American people to believe us when we say we are only covering 300 percent of poverty, or we are only covering kids?

On that point: We are only covering kids? I know it will be shocking to some—probably not to all—to find out that we currently cover 334,616 adults under the SCHIP program: 334,616 adults under the State Children's Health Insurance Program. Why? Because we allowed States to increase the eligibility under waivers because it was too tough to find the 5.4 million kids who were eligible under the original structure of the SCHIP bill that we wrote and passed in 1997.

In 1996, we conceived a plan, passed in 1997. It went for 10 years—$40 billion. It went for 10 years, $4 billion a year. Before we had ever gotten to the end of the 10 years we already changed the parameters, already changed the eligibility, we already put more money into it. We knew 10 years ago, now 11, soon to be 12 years ago, we needed to fix our health care system. We didn't do it under the Clinton administration, we didn't do it under the Bush administration, we didn't do it in the 104th Congress, 105th, 106th, 107th, 108th, 109th, 110th, 111th—well, maybe in the 111th Congress. We are in the 111th now.

And regarding the assertion that we should not have this health care debate? We should have this debate. We should fix it. For once, the Senate ought to step up and say let's quit continuing to do something that we know is broken and let's fix it. Let's not just increase eligibility of a broken program, let's fix the program. Let's not just talk about supplying an insurance product to a certain segment of America. Let's do it for everybody. Let's have an honest debate and discuss whether every American ought to be insured and let's have a debate as to how we get there.

Over the next 2 days we are going to talk extensively about this program. Today a Grassley amendment has been offered—it strikes the ability for legal immigrants to be brought into the program during those first 5 years. And a Hatch amendment which is very clear. If a State wants to bring in other people into the SCHIP program, then they have to verify that they have reached a threshold where 95 percent of the eligible kids are enrolled in the program. Mr. President, 95 percent of all the eligible kids would have to be in the program in order for this to be expanded—I think this is reasonable. If you are concerned with covering children, then I think this is a slam dunk amendment, and I might add it was part of the bipartisan bill last year.

The last amendment is Kids First, offered by Leader MCCONNELL. I might reiterate one more time, it spends $19.3 billion over 5 years.

It increases the enrollment in SCHIP by 3.1 million kids, as opposed to the Baucus bill that spends $34 billion over 5 years that increases enrollment by 5.7 million but does it by enrolling 2 million kids who are currently under their parents' insurance. That means our additional costs, the cost to the American taxpayer, is $4,000 per child for the additional 600,000 kids who would have health insurance for the first time under the Baucus bill because they are currently uninsured.

But we have options. We will have more amendments. We will have more debates. I look forward to working with my colleagues on what I think is a very serious piece of legislation.

I yield the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania is recognized.

Mr. CASEY. Mr. President, a couple of points: Obviously, based upon what my two colleagues have said this morning, we do not agree on a number of points. That is pretty obvious. But I think there is one area of common ground which maybe we can make progress on; that is, the point that was raised by both the Senator from Oklahoma and the Senator from North Carolina about the eligible but not enrolled.

I know one of the biggest problems over time, for example, in Pennsylvania with this program has been that you have a great program but not enough people know about it. If you do outreach by way of television advertising, that is the most effective by far, but any kind of outreach would be welcomed certainly by me and by those who are supportive of the legislation. The problem is, if we do not pass this legislation, all of the good intentions that I think are evident in what was said about getting people enrolled is without merit. So that is an area on which we can agree.

I have to say, one of the things I get from this chart with the carriers on it, one of the points that has been made about this is, because it is a Federal and State program that is obviously supported by public resources, the impression is that somehow it is a 100-percent public program, it is just growing government, and the usual arguments that are made against it.

I understand the philosophy behind it. This is often lost; that this is indeed now for 15 years, and will be, a very successful public-private partnership. These, for example, are in Pennsylvania, the private providers for the Children's Health Insurance Program in our State: Aetna, Ameri Choice, Capital Blue Cross, First Priority Health, Highmark, Highmark Blue Cross Blue Shield of Western Pennsylvania, Keystone Health Plan, Unison Kids and UPMC for Kids. This is the very definition of a successful—remarkably successful—public-private partnership where hundreds of thousands of children in our State and literally millions across the country have been provided health insurance.

With regard to the numbers, where are we now in terms of covered versus not covered under this program? Nationally, the covered number is 6.7 million right now. The number of children who are not covered amounts to 4.1 million children. And 83 percent, or 3.4 million of those 4.1 million uninsured covered by the legislation are currently eligible.

So we have all of these children, more than 4 million children, who are eligible but are not enrolled. Some of the issues we talked about earlier about enrollment, simplifying paperwork, and eliminating bureaucratic areas, we should work on that, and that is what is contemplated by this legislation: funding for outreach and enrollment, which has been pushed by people in both parties in connection with this legislation, and incentives to States to encourage them to provide coverage for those who are eligible but not enrolled.

The point was made also about bipartisanship. Look, the definition of bipartisanship does not mean unanimous. I realize in the Finance Committee there was more Democratic support than Republican support. But the fact remains this program, the birth of this program and the continuation of it, has been bipartisan. The votes in 2007 were evidence of that, and I think even the debate today and the support—I should say more than the debate—the support is bipartisan.

When this is voted on in the Senate, you will have a lot of Democratic support, obviously, but you will also have significant Republican support. That is the definition of bipartisan, in my judgment. Maybe it is in the eye of the beholder, but I am trying to emphasize this is indeed bipartisan.

We are going to have time today in the hours ahead of us on the question of immigration. Two points I wanted to make: One is the 5-year bar. Basically,

what we are talking about is a restoration of something that was in place before. Prior to 1996, lawfully residing immigrants, those holding green cards and those defined as ''permanently residing under the color of law,'' those individuals, prior to 1996, were indeed eligible for Medicaid. And this amendment, the Rockefeller-Snowe-Bingaman-Kerry-Wyden, a lineup of names that is bipartisan, by the way—that amendment offers a restoration of eligibility for only some of these immigrants: children and pregnant women who are here lawfully—lawfully—who intend to remain in the United States and who meet all other Medicaid and CHIP eligibility requirements. That is what we are talking about. We are talking about children, legal immigrant children, and pregnant women.

Removing the 5-year bar could help States provide coverage to additional low-income children. What do we mean by that? You would think, listening to this debate, that removal of this is somehow brandnew, that it has never happened before, and no States are doing that. In fact, right now 23 States use their own funds to pay for health coverage for lawfully residing immigrants, immigrant children. Let me say that again: lawfully residing immigrant children or pregnant women, those 23 States, during the 5 years, who have become ineligible for Medicaid or CHIP. If this 5-year waiting period were removed, these States could secure Federal matching funds which would free up State funds to cover additional low-income children.

So this is something States are wrestling with now, and what this would do is provide an option for States to have some help in the coverage they are providing for those individuals. So it is nothing dramatically new, but I think it is humane, and it is prudent based upon what has happened with this program over time.

Let me make one other point about the issue of legal immigration and the so-called public charge: Nothing in the bill changes the agreement a person makes when sponsoring an immigrant, when an immigrant comes to this country. Citizenship and Immigrant Services, so-called CIS, does not consider participation in a public health program a failure to support the immigrant. Longstanding Citizenship and Immigration Service guidance makes it clear that immigrants will not be considered a public charge if they use health care benefits, including Medicaid and CHIP, prenatal or other low-cost care at clinics. So when we are talking about this issue, it is important to put that on the table, what Citizenship and Immigration Services would consider to be a public charge.

I want to get back to some of the provisions in the bill. I wanted to get that chart on rural children. One of the discussions we have had over many months now is, Who benefits from this program? Certainly, children across the board, children in urban and suburban communities. But what is often not emphasized is—and I want to make this point because I have a significant part of our State that is rural, and most of our State, when you get outside of the major urban areas of Philadelphia and Pittsburgh, is indeed rural. Rural children are more likely to be poor. Nearly half of rural children live in low-income families at or below 200 percent of the poverty level.

In this economy, when you consider the confluence of bad circumstances for rural children and rural families, here is what you have: escalating costs for energy, which disproportionately affects rural Americans; significant job loss in rural communities; an inability to have access to health care—I should say a lack of access to health care in rural communities. All kinds of problems.

This bill, among the many other good things it does, would have a disproportionately positive impact, in my judgment, when you look at the data on rural children. Rural children increasingly rely on children's health insurance. More than one-third of rural children rely upon the Children's Health Insurance Program or Medicaid. One-third of rural children rely upon one of these two programs.

So in this debate it is important that we stress the broad reach of this bill as it pertains to children from across the board, across the demographic and even economic landscape.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. I will make this short because I know we have a swearing in.

I wanted to make a few points. When President Obama talks about being responsible, if you sign an affidavit that you will cover and be the sponsor for a legal immigrant in this country, you ought to do that. That is what he is talking about. He is not talking about: I will do it until I can get someone else to take care of my responsibility, talking about it, if you sign an affidavit that you will do it.

The idea that 22 States already do this is great. If States want to do it, that is what makes our Union so great, that 22 States can, except now they cannot afford to do it, and we are going to be bailing them out to the tune of about $300 billion on Medicaid and SCHIP programs in the supplemental or the spending package or the stimulus package that is coming through.

What this bill is going to do is make permanent that people do not have to be responsible when they, in fact, sign an affidavit that they will sponsor a legal immigrant.

One final point I would make is, the Senator from Pennsylvania listed all of those premium assistance programs that Pennsylvania has because that is what they are, premium assistance rather than a regular SCHIP program. Well, in this bill you have extremely limited any new premium assistance programs without an absolute mandate and an absolute mandate on what kind of program you have. You will be in an HMO. You will not have the doctor of choice, and you will not go where you want; you will go where you are sent.

So great points, great need in our country, great debate, but integrity first. Be honest with the numbers about what they really mean. Everybody in this Chamber knows they are not, but we are not going to change that. Even if we offer an amendment, it is not going to go anywhere because nobody knows what to get rid of to be able to afford to pay for that.

I yield the floor.

Mr. CASEY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. I ask unanimous consent that the order for the quorum call be rescinded.

CERTIFICATE OF APPOINTMENT

The VICE PRESIDENT. The Chair lays before the Senate a certificate of appointment to fill the vacancy created by the resignation of former Senator Hillary Rodham Clinton of New York. The certificate, the Chair is advised, is in the form suggested by the Senate.

If there is no objection, the reading of the certificate will be waived, and it will be printed in full in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATE OF NEW YORK

Executive Chamber

CERTIFICATE OF APPOINTMENT

To the President of the Senate of the United States:

This is to certify that, pursuant to the power vested in me by the Constitution of the United States and the laws of the State of New York, I, David A. Paterson, the Governor of said State, do hereby appoint Kirsten E. Gillibrand a Senator from said State to represent said State in the Senate of the United States until the vacancy therein caused by the resignation of Hillary Rodham Clinton, is filled by election as provided by law.

Witness: His excellency our Governor David A. Paterson, and our seal hereto affixed at 11:00 a.m. this twenty-third day of January, in the year of our Lord 2009.

By the Governor:

DAVID A. PATERSON,
Governor.

LORRAINE A. CORTÉZ-VÁQUEZ,
Secretary of State.

[State Seal Affixed]

ADMINISTRATION OF OATH OF OFFICE

The VICE PRESIDENT. If the Senator-designate will now present herself at the desk, the Chair will administer the oath of office.

Mrs. GILLIBRAND, escorted by Mr. SCHUMER, advanced to the desk of the Vice President; the oath prescribed by

law was administered to her by the Vice President; and she subscribed to the oath in the Official Oath Book.

The VICE PRESIDENT. Congratulations.

(Applause, Senators rising.)

RECESS

The VICE PRESIDENT. Under the previous order, the Senate stands in recess until 2:15 p.m.

Thereupon, at 12:34 p.m., the Senate recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. CARPER.)

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009—Continued

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BROWN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, today with the advent of the 111th Congress, the Senate is considering legislation to renew and expand the Children's Health Insurance Program, sending a clear and definitive message that this country will no longer turn its back on our 9 million uninsured children.

When we pass this bill, we will make it clear that the health and well-being of our children—in bad economic times or, in the future, in good economic times—the well-being and health of our children comes first.

After 2 long years and repeated vetoes from former President Bush, this legislation finally has a chance of becoming law, thanks to the support of a new President who is committed to reforming our Nation's health care system.

It is my sincere hope that the passage of this legislation will be the beginning—the beginning—of a major overhaul of American health care, which ultimately will provide all Americans with the quality, affordable health care coverage we all deserve as Americans.

The Children's Health Insurance Program is a success story. It was created about 13 years ago, in 1996, to provide health coverage to children who would otherwise not be insured. The program provides health insurance to low-income families who do not qualify for Medicaid but who are unable to afford private coverage, to reduce the number of uninsured children in working families—underscore that, Mr. President: in working families—by about one-third.

Despite its huge successes, there is room for improvement. Sadly, millions of American children remain without health insurance, even though the law states they are eligible for it.

Today, we have an opportunity to take decisive action to bridge that gap and to reach children who need this coverage desperately but who are not receiving it. The legislation before us today would provide coverage to an additional 4.1 million uninsured low-income children. It would improve access to dental coverage. It would improve the public health by enabling legal—legal—immigrant children to receive care in doctors' offices rather than taking them to more high-cost, less primary care, emergency rooms.

If signed into law, S. 275 would have a profound impact on children and families nationwide, including in my State of Ohio, including Toledo and Akron and Canton and Mansfield and Cincinnati and Bellaire. It would provide approximately $294 million to Ohio in fiscal year 2009, helping my State cover approximately 245,000 uninsured children—children such as Emily Demko from Athens County.

Emily was born with Down Syndrome. When her mother Margaret made the decision to stay at home to care for Emily, their family found themselves without health insurance. The Demkos looked into many options, but no private insurer would cover Emily, at any cost, due to her genetic, preexisting condition. Luckily, the Demkos found they were eligible for Medicaid. However, during their 6-month reauthorization meeting, they were informed their income was—get this—$135 per month too much to qualify any longer. Mr. President, $135 too much to qualify for Medicaid any longer.

Since Emily's medical bills were in excess of $3,500 a month, the Demkos had to make decisions no parent should ever have to make. They had to decide what therapies and treatment they could afford for their daughter.

Although they have done their best to manage Emily's medical care, being uninsured has left Emily without access to needed hearing tests, corrective treatment for an eye condition, and several blood tests to scan for conditions likely to occur with Down Syndrome.

It is for children such as Emily that we must support the reauthorization and the expansion of CHIP. Access to health coverage will provide Emily and so many others around our great Nation with the opportunity to live a healthier, happier, more productive life, regardless of their medical condition.

For the third time in my Senate career, I have come to this floor to advocate for the reauthorization and expansion of the Children's Health Insurance Program. I did it in the House 13 years ago, when this program was first conceived and when we first enacted it.

For the third time in my Senate career, I have come to the Senate floor to speak on behalf of the 9 million children in this country who do not qualify for Medicaid but whose families cannot afford health insurance.

For the third time in my Senate career, I have come to this floor to cast a vote in favor of legislation which will enable parents to help their children when they are ill. In my opinion, there are few legislative or ethical priorities more important than that.

This is the third time I have advocated for CHIP on the Senate floor. I believe, I hope, the third time will be the charm.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BROWN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. BROWN. Mr. President, there was an amendment offered earlier by Senator HATCH with whom I sit on the Health, Education, Labor and Pension Committee. Senator HATCH has played a major role in health issues in this country and I respect him for that. His amendment, however, to this bill is sort of the same old same old. We have seen this throughout the Children's Health Insurance Program debate. We saw it last year both times when the President vetoed the bill. We saw it raised by opponents in the House of Representatives. We saw it raised many years ago. When the amendment says States should have to enroll at least 90 or 95 percent of their kids under 200 percent of the Federal poverty level before they can enroll children at higher income levels, it pretty much says no more children in the Children's Health Insurance Program. I wish they would simply be more direct saying, We don't want more kids in here. Instead, they say if you can't find close to 100 percent of these children who are eligible—this is a big country, it is a complicated country; so many of the people we are trying to insure are living economically on the margins. There are two children with a single parent who has moved from one job to another. Those children often move across town or to another county as their mother or father get another job—a job that may pay $20,000 a year and a job without health insurance—so the Children's Health Insurance Program is so important to them. So when they build in this ''standard'' that virtually everybody—95 percent of all children eligible have to be enrolled before you can enroll new children who are a little bit better off—a little bit better off isn't a family making $100,000 a year; it is a family making much less than that without health insurance and simply can't afford it. Even mandatory programs we have found around the country don't have a 95-percent take-up rate. It is simply impossible for Government or for private businesses

or for social services working with Government to get to 100 percent of the people who are eligible. So what this does is say no more children would enroll.

We know health insurance is becoming less and less affordable for families at every income level. I know what has happened in my State. As the Senate majority leader told us earlier today—an hour ago—85,000 people in this country lost their jobs today. Eighty-five thousand people lost their jobs today. In my State, we have lost 200,000 manufacturing jobs in the last 8 years. It was 200,000 as of last October. That number has gone up. We hear about plant layoffs such as the third shift at Lordstown in northeast Ohio, a General Motors plant that assembles goods. As the Presiding Officer knows from what has happened to his plant in Delaware, we know what happens when people are laid off from these jobs. They cut off the third shift at Lordstown. We are seeing Wilmington, DHL in southwest Ohio, 7,000 jobs over a several week period have been terminated in a city of about 13,000 people. That DHL plant is the largest employer in a six-county area, in each of these six counties—in Clinton County, Brown County, Adams County, Highland County, and two other counties.

The point is we don't want with this economic downturn—we don't want to turn back the clock. It is the worst possible time to cut back on States' tools for helping low-income children. We want these children to become insured, not to find ways to deny coverage. The Hatch amendment does that. That is why it is so important later today, if and when we vote on this amendment.

Another point. There are about 150,000 children in my State. My State has a population of around 11 million. There are about 154,000 of our children in my State—enough to fill Ohio State Stadium. The Presiding Officer, even though he is from Delaware, is an Ohio State graduate. He knows how big that stadium is. It holds more or less 100,000 people in one place—Columbus—in the heart of the State. There are 150,000 children who don't have insurance, enough to fill that stadium one and a half times. That number grows. That was sort of yesterday's number. That number grows every day. Ohio has already lost 100,000 jobs in this recession. If the pace of job loss accelerates this year as expected, more and more children will suddenly become uninsured. President Obama has already said the 2009 economy is going to be even worse than the 2008 economy. That is why Senator INOUYE and so many others in this body, Senator MIKULSKI and others on the Appropriations Committee, are working so hard to put a stimulus package together that will have an impact as quickly as possible as we work our way through the second year of this recession.

In these tough economic times, the risk of being uninsured is even greater. Many Ohio families, as we know too well, are only one emergency room visit away from bankruptcy and foreclosure. Too many have declared bankruptcy, too many people have lost their homes to foreclosure, too many people have lost their jobs to this recession. We should not turn our back on them in providing health insurance to their children. Again, these are mostly people who are eligible for the Children's Health Insurance Program, mostly children in families where mom or dad or mom and dad have jobs and simply are not making enough to buy health insurance and those employers for whom they work simply don't have the ability to provide insurance to these families. That is why this legislation is so important. That is why defeating the Hatch amendment is so important.

I would add that in the Hatch amendment, the 95-percent rule is especially for those who want to enroll legal immigrant children and pregnant women. Again, that is a standard I don't think we can meet, because no matter how hard these States try, they can't find 95 percent of the people who are eligible. That will mean too many children of legal immigrants, legal people in this country, too many pregnant women simply would not have insurance for their children that we should offer them in this body.

Mr. President, I note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. KYL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

The Senator is recognized.

Mr. KYL. Mr. President, the legislation that is before us is a reauthorization of the Children's Health Insurance Program, but it is, as I said yesterday in my remarks, seriously flawed in a number of respects. Because of that, the minority leader, the Senator from Kentucky, and I have offered an alternative. It is called the Kids First Act. The Kids First Act is an effort to reauthorize this important program but address the numerous flaws in the pending proposal so we can adopt something that literally puts kids first.

I spoke yesterday about several of the problems with the underlying bill. First, the problem of crowding out private coverage. We created this Children's Health Insurance Program in order to help families who did not have insurance. But the bipartisan Congressional Budget Office has noted that because of provisions in the underlying bill, there are actually over 2 million people—in fact, 2.4 million people—who will go to the Government insurance program who already have private health insurance that is perfectly adequate to their needs. The reason primarily is because their employers obviously appreciate the fact that it is costing them money to insure their employees' families and it will be a lot cheaper if those families go to this Government-run program. Our effort was never to cause people to leave the health insurance coverage they have to come to a new Government program. Our effort, when we adopted the kids insurance program, was to provide insurance for those who did not have it already.

This crowdout effect is well known, and it is well understood. It can actually be quantified as the Congressional Budget Office did. Last year, we offered a couple of amendments to ensure that the crowdout effect would be minimized. The amendment I offered was not adopted. But recognizing that there was a serious problem, when the Democratic leaders in the House and the Senate wrote the bill that ended up passing both the House and the Senate, though it was vetoed, it was supported by Democratic majorities in both the House and Senate, and it had some language related to crowdout. I thought it was insufficient language, but nevertheless I understood the necessity of dealing with the issue.

That language is not in this bill. So in the committee, I offered the Democratic language. The Senator from Montana, the chairman of the committee, helped draft it. As I said, it was supported by Democratic majorities in both the House and Senate. Essentially on a party-line vote, that amendment was rejected.

We need to deal with the problem of crowdout. The legislation Senator MCCONNELL and I have drafted does put kids first. It tries to deal with the problem of kids who do not have insurance rather than taking families who are already insured and transferring them to a Government program.

Another problem we spoke of is the fact that as this program has expanded, it does not just relate to families who are at the poverty level or even twice the poverty level but three and four times the poverty level. In other words, it can actually cover families in two States—up to $88,000 a year in New York and about $10,000 less than that in New Jersey. That is clearly wrong. We are trying to talk about low-income families. In fact, if you add other assets of a family that are not counted in income, you could literally have $40,000 in additional assets and, in New York, be making $128,000 a year for a family and be eligible for this low-income children's health care—$128,000-a-year income. That is wrong. What that does is take money from the State of the Senator from Oklahoma, it takes money from my State of Arizona and other States and transfers that. We are trying to be as frugal as we can. Our limit is 200 percent of poverty. That is twice the poverty level. That is what we pay for in Arizona. But we are having to pay for more than twice that much for families in New York. That is not fair. The program Senator MCCONNELL and I have offered as an alternative deals with that problem as well.

In addition, we ask that people demonstrate that they are eligible for this coverage. That has always been a part of the program. The bill that is before us weakens those provisions so that you do not have to have the same kind of documentation that you are eligible for the program. It expands the program to legal immigrants in this country who have always had a contract that they will not become part of our public welfare system.

One of the really interesting things is the budget gimmick that is used which Senator MCCONNELL and I believe should not be part of this program. It is a budget gimmick to circumvent the Senate's so-called pay-go rules by which we ensure whatever the costs are, there is a way to cover those costs. The way that is done is that the program, even though it is a 10-year program, as all of our authorizations are—after 5 years, there is just an assumption that it does not cost very much anymore. Of course, under that assumption, we would have to disenroll millions of people from this program. That is never going to happen. Everybody knows that. Everybody knows that gap in financing would be filled, and as a result, the program would actually cost $40 billion more than it is alleged to cost as the bill came out of the committee. And that is by CBO's number, $41 billion-plus.

Those are some of the deficiencies with the legislation.

The amendment Senator MCCONNELL has offered, the Kids First Act, is very targeted and I think a much more responsible approach to the problem. It does reauthorize the children's health care insurance program. It preserves health care coverage for millions of low-income children. It actually adds 3.1 million new children to SCHIP. It minimizes the reduction in private coverage, the so-called crowdout I spoke about earlier, by targeting SCHIP funds to low-income children, not higher income families who may already have access to insurance. By the way, it is offset without new tax increases or a budget gimmick such as the program before us is.

I encourage my colleagues to ask us questions about this amendment. If they have concerns about it or would like to debate, I would love to have that debate on the floor, if anyone would like to engage me in a discussion about why this is not a superior alternative.

The bottom line is, we have two choices. We have a budget buster that does not protect SCHIP coverage for low-income children, that represents an open-ended financial burden on taxpayers and takes a significant step toward Government-run health insurance or the amendment Senator MCCONNELL has filed, a fiscally responsible SCHIP reauthorization that preserves coverage for low-income children. It is fully offset without a budget gimmick or a tax increase, and it minimizes the so-called crowdout effect on employer-sponsored health coverage that people have today.

I think the answer is clear. The Kids First Act is the right solution. And when we have an opportunity to vote on that, hopefully a little bit later this afternoon, my colleagues will take a good hard look at it and see if they don't agree that is a good approach to the reauthorization of SCHIP and support the McConnell amendment.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I appreciate the comments of my friend and colleague from Arizona. The minority leader filed this amendment in 2007. It was not a good idea then. It simply knocks too many children. These are not rich kids. These are sons and daughters of people who are working who are not making a lot of money, are not making enough that they have health insurance or can afford out-of-pocket health insurance. They are working for employers who do not provide it—small businesses, lower income workers. I don't want to do anything that takes away the eligibility of those children.

When I hear about the crowdout provision Senator KYL discussed, I want to make a couple of comments about that. I just don't think it exactly is going to work that way.

The CHIP statute already requires States to determine and monitor whether crowdout is occurring and adopt policies to limit crowdout if it does occur. Most States that cover children at more moderate income levels have imposed 3- or 6-month waiting periods to prevent families from dropping employer-based coverage to enroll in CHIP. There may be a time when families are not going to want to do that.

It is not as though States want to give away this money. States are squeezed today every bit as much as many families are squeezed. States already have a strong interest in monitoring and preventing crowdout. They don't want to spend limited resources on children who already have private health insurance.

This bill does a good job of targeting the lowest income children. The new enrollment options, the performance bonus, and the outreach funding all help to achieve everyone's shared goals to ensure that the most vulnerable are covered.

We accept that our friends on the other side of the aisle want to insure people at 100 percent, 150 percent of poverty, but we also want to extend this to families who still do not have insurance for their children because of their economic situation. These are not Congressmen's kids. These are children whose parents are working at places that do not offer insurance and do not make enough money that they can out of pocket come up with health care coverage for their children.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, I wonder if anybody has ever asked the question—it has certainly never been answered—if you are a family and you qualify at the new 300 percent and you are buying your own insurance and you are covering your two kids, what happens when you transfer your kids to SCHIP, the Children's Health Insurance Program? What happens to your premium? I can tell you what happens to the premium. Do you know what happens to the premium? It goes down zero because health insurance is sold as an individual or a family product. So by taking two children, if I am earning 300 percent of poverty, and taking them off and transferring—now I am paying for it—and transferring that to the State Children's Health Insurance Program, the taxpayers of this country now will pay for that premium about $2,200 a piece when you can buy it in the private market for $1,100 a piece, but the parents will get no decrease in their insurance premium. That is why the crowdout provision is so negative for the American taxpayer and the generations that follow us.

My friend, the Senator from Ohio, mentioned that everybody wants to cover the 200 percent and below. The fact is, we have done a terrible job of covering the 200 percent and below. There are 5.4 million children out there today who do not have health insurance, whose parents do not have health insurance, who are eligible for Medicaid and SCHIP today, and they are not signed up. What are we doing? We are expanding a program that has only gotten about 51 percent of the kids who are eligible right now signed into the program. We are also being dishonest about what it costs. It is actually going to cost $42 billion more than what we say it is going to cost. Nobody will deny that. So why would we not want to have something that will limit the amount of crowdout because as we take money for kids who are now insured and put it to them through a Government program, it means these same 5.4 million kids are still not going to get covered.

We have not improved the program by increasing the eligibility. What we have done is we have just moved the income scale up to $60,000, some $62,450 a year, and we say: We will now cover your kids, and even if you have them covered now, you will not get any break from your insurance. But the same 5.4 million kids who are in poverty or at 200 percent of poverty still are not covered.

What are we doing? Why wouldn't we want to fix it to where all the kids who are out there today who do not have insurance, who are 200 percent and below the poverty level, why aren't we making sure they are covered? Why are we not doing that? Why are we not saying: States, you can go to the 300 percent if you want but only after you have covered the kids whom the program was designed for in the first place.

There is an amendment by Senator HATCH in that regard. Why would we spend all this extra money?

By the way, we just met with the President. Other than the short-term financial struggles we are in, one of the big concerns with him is the fact that we have an unending entitlement disaster before us and we are getting ready to make it worse. Why would we not address that? Why would we say we are going to help kids but not really help kids? Why would we say we want to help the poorest children and the families who need it the most but still ignore them?

There is an answer to it. There is an answer to it, in that we want to move whichever way we can to eventually have a single-payer system in this country. We gutted the Premium Assistance Program. The Senator from Pennsylvania listed all the great things about the Premium Assistance Program. He listed all the different programs in Pennsylvania. Those are gutted under this bill. You can have one, but by the time you get it, nobody will want to have it.

We have taken what people have and said maybe we could spend $500 per kid per year to keep them in a health insurance program that the parents might have at work, but instead we are taking them all out and putting them in a Government program that costs twice as much as it does to buy them the same insurance in the open market.

Crowdout is a real phenomenon, but the most important thing is it helps the people who need it the least the most. And it helps the least those people who need it the most. That is what we are doing in this bill. We are not helping the lowest. We are only moving it up the chain and we are saying if you make $62,000 a year in this country, your children can be covered by the Government.

Why would you not want to do that? We do not have any other Government program that people do not voluntarily take if we put it out there. That is in the face of the fact that this year—hear my words very clearly—this year the true Federal budget deficit will be $1.6 trillion. The Government will spend $24,000 per family more than it takes in. Hear those words—$24,000 more per family it will spend than it takes in.

What is the future to be for this child at the 300 percent above poverty level? Their parents make $62,000 and we are going to give them this gift of health insurance today. But you will not be able to afford a college education. You certainly will never afford a home. It is doubtful you will ever be able to afford a car that is reliable. You will be in a debtor nation. Those are the consequences of our actions in the name of wanting to expand a program that today is highly ineffective in addressing the needs of the real poor children in this country.

Why would we do that, and just say: Don't worry, you have a pricetag to pay if you ever hope to get out of college or have the ability to get out of college? By the way, we are going to up your taxes if you get out there and get it up here on the front end.

This body is abandoning the very principles this country was built on. This country was built on a heritage of sacrifice, sacrifice by the common man for the common good to create a great, bright shining future for the generations that follow. This bill doesn't fit with that heritage. This bill, as a matter of fact, undermines that heritage. In the name of helping children, we are hurting those children's children. We are stealing opportunity from those children's children.

As I said earlier this morning, I want every child in this country insured. If we took the money that was out there today in Medicaid and SCHIP and the State contribution to it, we could insure every child in this country. We could create an insurance policy for every child in this country that gives them total screening exams, could give them prevention care, could give them acute care, and could give them hospital care. Yet when we run it through the Government, it costs twice as much because of the inefficiencies that are inherent in the system.

Later on I am going to offer a limitation based on improper payments. The American public may not know this. Certainly Members of Congress know. We do not know how much money is wasted in Medicaid because Medicaid has refused to report it. By law they are mandated to report it. They have refused to report it. We now have the information on 17 States on improper payments. The average is 10.5 percent on the 17 States we have looked at. Of that, 90 percent of those are overpayments. In New York City alone their own inspector general said at a minimum $15 billion a year is wasted in fraud, abuse, and deceit on the Medicaid Program. Where have we addressed any of that in this? Where have we put the safeguards to make sure this doesn't happen here? We have not done that.

We are not fixing the problems that are in front of us. What we are doing is creating more problems in the name of expanding a children's insurance program and limiting the future of the things that have been very successful with it, such as premium assistance, and taking that away.

There is going to be crowdout and the crowdout is going to benefit the most wealthy of the upper middle income because in some States, by the time you count exclusions, you can earn $120,000 a year and have your kids on SCHIP. We are going to help them. But not the kids of the parents working at $7 an hour, both of them, making $28,000 or $30,000 a year, of which half of them are not on either Medicaid or SCHIP. Why would we do that? Do we truly care about children's health? Are we really about trying to solve it?

Where are the ideas of combining where the biggest health care disparities are in our country? We know where those are. Why not design a program to go and attach and direct health care dollars to the large health care disparities? We know it pays big returns in terms of childhood obesity, in terms of precluding the onset of smoking, in terms of prevention and vaccinations, in terms of well-child care? Why would we not look at where the problems are and try to direct dollars to where the problems are? Instead, we are going to allocate across this country, to those who can now afford it, we are now going to start paying for it.

Even if we wanted to do that, why would we do it at twice the cost of what you could buy in a private market? Mr. President, $1,156 is the average market cost to insure a child in this country. Why would we spend $2,200 to get the same thing? So we can say we did something?

If, in fact, you could take $1,156 or $1,200 for every child out there—we have more than enough money with what we are spending today to accomplish that—we could buy them all an insurance policy.

I am not sure this bill is about children. I am not sure it is about children's health care. I have some doubts when we are not frugal. If it is about children's health care now, it is certainly not about those children's long-term financial security, when we are not even going to be honest with how much this bill costs. We have pulled a trick so we do not have a pay-go rule, and the trick keeps us from offsetting $42 billion in expenses associated with this bill. Everybody knows that. Nobody will say that is not right. Nobody wants to talk about that. That is what is wrong.

That is why people do not have confidence in the Congress. It is because we have this sleight-of-hand. We want to do something good but we don't want to tell you what it costs and we don't want to get rid of programs that don't work in order to be able to do something good. We are going to hide it under the blanket. So we are hiding $42 billion under the blanket. We are playing the inside baseball game, not being honest with the American people about what it costs; not being honest with the American people that it is a lot cheaper to give premium assistance than it is to give a program directly to a child; not being honest about the fact that this costs twice as much as what you could buy a health insurance policy for, for every child in this country.

We are not being honest at all, so our integrity is in question. Would we do the right thing in the long term for these kids that we say we care about their health care? I do not have the confidence we will. I have the confidence that this train is going to roll, we are going to do it just the way we have done it. There are still going to be 5.4 million kids out there 10 years from now, when we look at eligibility. It will be the same 5.4 million under the 200

percent of poverty level that we did not reach, that we didn't get out and actually make a difference. And then we are going to pay a larger cost as they mature as adults because what we could have prevented will not have been prevented, what we could have taught will not be taught, and the health care costs associated with that will be tremendous.

Mr. President, 5.4 million children are presently eligible for either SCHIP or Medicaid and we have done nothing to make sure those kids get a program that is readily available to them today. We have done nothing. We put $100 million in for outreach and said we will feel good about it because maybe that will reach some of them. We will still have millions of children who are eligible for these programs who will not get it.

We are going about approaching it the wrong way. We ought to be saying let's have a bill that insures every American child. Let's do that. Every American child, universal access with an insurance policy for every American child, why won't we do that? That is what we should be doing. Let's do it for every child. Then the insurance rates on adults will modulate and then husband and wife will not be paying a falsely elevated price once their kids get pulled off of their insurance policy and go into a Government program. Why not buy them all something, from then until the time they are 21, that covers them, that gives them the prevention care, that gives them the counseling, that gives them the immunizations? We know what it costs and we know what we can do it for. Why not do that?

Instead, we have created this complex, convoluted system that can be gamed. The estimate on Medicaid fraud—listen to this—the estimate on Medicaid fraud is $60 billion a year. That is enough to pay for where we cheated on this program if we would get rid of 10 percent of it a year over the next 10 years, if we got rid of 10 percent of the fraud. There is nothing in here on fraud. There is nothing in here to make the States accountable for the money we send out there.

We have done a poor job. We claim we want to help children, we claim we want children to have health insurance, yet we mortgage those very children's futures by not being honest about how we are going about doing it, about how we are going to pay for it and what the ultimate results will be.

I yield the floor.

The PRESIDING OFFICER (Mr. SANDERS). The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I appreciate as always, even when we disagree, the words of the Senator from Oklahoma. He and I have worked, from our time in the House, on international health legislation together. We come at things from very different perspectives. But I often come down in the same place. I would love to hear more about his plan on children's health, to extend universal coverage to all children.

I was driving to the airport this morning after leaving my mother in Mansfield, and heard Bill Considine, who is the president of Akron Children's Hospital, one of the premier children's hospitals in my State and in our country. Mr. Considine, the CEO of that hospital, had some interesting things to say about what I believe he called Kids Care, which may be similar to what Senator COBURN was talking about.

I hope we can work some things through there. I want to disagree, though, for a moment briefly with Senator COBURN's comments about we absolutely want to—we do not want 50 percent of children covered who are at 200 percent of poverty or 300 percent or beyond for that matter.

We obviously want to do better. We have done generally fairly well locating those children and signing them up, those children who are eligible.

This legislation goes a good bit further, and the efforts to, if you will, encourage and find those children who are eligible and sign them up, those efforts have been very bipartisan in the last dozen years.

The Presiding Officer from Vermont has been part of this. He has always had an abiding, intense interest with what we do with children's health care. I extend this back a couple of sessions ago—Senator FRIST, the Republican leader, and Senator BINGAMAN, a Democrat from New Mexico; and Senator LUGAR, a Republican from Indiana, with Senator BINGAMAN; and at other times Senator GRASSLEY, a Republican from Iowa, Senator HATCH a Republican from Utah—all of them have been part of, and many on my side of the aisle have been part of, finding ways to get people to sign up, simplification of paperwork and bureaucratic requirements, including language directly from legislation introduced by Senators LUGAR and BINGAMAN; providing funding for outreach and enrollment, which is language originally introduced by Senators FRIST and BINGAMAN and pushed and supported by Senators GRASSLEY and HATCH in the legislation in the last Congress.

It provides for incentives for States to encourage and to provide coverage for those eligible but unenrolled children. We can certainly learn from Senator COBURN to do more, but this legislation is replete with provisions to bring in more children. It does not mean we do not enlarge the eligibility to 300 percent of poverty, nor does it mean we do not look down the road, I hope, sooner than later with the relationship that Senator COBURN has built with President Obama, both as freshmen Members of the Senate and since Senator Obama has become President, to work together in finding ways to do this.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I thank my colleague for his comments. There is an easy way to solve this; it is called auto enrollment. You just write a bill. Anybody in any region under 200 percent who has a claim of deduction for children is automatically enrolled in SCHIP or Medicaid. It is not hard. We do not want to do that. Why are we not doing that? Because we do not want to help all of these 5.4 million children. We do not want to do that.

We have all of these incentives that have not worked in the past. We have done all of these things. All you have to do is auto enrollment. We can write a law. We can pass it. We can say: The IRS can look at every family who has children under 200 percent who files a tax return or files for the earned income tax credit, and their children are automatically enrolled. They automatically get a notice that says: Here is your insurance. Here is your State card. You have coverage.

It is not hard. We can do that. But we have not done it.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mr. BURR. Mr. President, I wanted to pick up where I was before lunch. I am glad to see my good friend from Ohio. We were having conversations before lunch on this bill. Clearly, it is an important piece of legislation.

As Dr. COBURN and I said before lunch, I think every Member of the Senate, I think every Member of Congress, and probably everybody in the country believes it is important that we cover children; that the prevention and wellness aspects of having coverage means we have a healthier community; that we take those who, by the way, are historically more healthy, younger folks, and we give them the assurances of check-ups and the ability to visit a doctor so that we minimize anything that can happen to them. In 1996 and 1997, the Senator from Ohio and I were both on the Energy and Commerce Committee. We were involved in crafting the original legislation. I remember it today as well as I do then. The legislation was targeted at a specific group of our country's children: those over 100 percent of poverty whose families made too much for Medicaid but those with not enough income between their parents to be able to afford health care at the time.

My gracious, health care has done nothing but get more expensive since 1997. We appropriated and authorized $40 million for a 4-year program. The target—I can't remember what the target was for the number of kids—but today, at 100 percent of poverty for a family of four, they would have an income of $22,000. At $22,000 they apply for Medicaid, regardless of what State they live in, and health care is provided under Medicaid for that family.

As Dr. COBURN pointed out, I think rather clearly, for Medicaid and SCHIP today, we have probably eliminated access to about 40 percent of health professionals because they choose not to

participate in the programs. Why? It is because the reimbursements are so pitiful in those two programs, regardless of the State. Doctors have chosen to opt out of providing that care and focus just on the Medicare and private market or just on the private market.

So just the creation of Medicaid and SCHIP means we have eliminated some choices for these people where this coverage is their only option, it is their safety net. Now, if I had my druthers, I would rather be here debating overall health care reform because I believe every American should have the ability to be insured.

I am not sure I would have much disagreement in Congress or in America on that. We will have a big disagreement on how we get there, but we can get there. Were we to have that debate today, we would not be here talking about the expansion of one program that hits a small group of Americans and is targeted to put them in a one-size-fits-all program that only 40 percent of the health care professionals even participate in.

Now, having said all of that, SCHIP is up for reauthorization. We are now 10 years down the road, and we are talking about, How do you change this bill to apply what we have learned? Can we reach new efficiencies in cost? Can we cover more people? If so, how? Which States have done well? Which states can we learn from? Which have done poorly? Which states should we work with in the legislation to try to prod?

Well, we find in this legislation that in 10 years, we have moved from 200 percent of poverty to 300 percent of poverty. I do not have any big disagreement with that, with the rise in health care costs. Three hundred percent of poverty for a family of four is $66,000 a year.

So under this program—SCHIP currently, not under the reauthorization bill—if a child lives in a household that has an income of $66,000, above $22,000, they are eligible in several states for SCHIP today.

So what is our experience so far? As we get ready for this reauthorization, we have 7.4 million children enrolled in SCHIP in 2008. But the average monthly enrollment for 2008 was 5.5 million, meaning that somewhere, somehow we have had almost 2 million drop out. They have moved to a different State. The income of their family changed. They are no longer eligible. So 5.5 million covered children today seem to be sort of the fixed point.

Well, how many are eligible today but not covered? I think my colleagues would be amazed to find out it is 5.4 million. We are covering 5.5 million, but we are not covering 5.4 million who are eligible under today's guidelines.

So in typical Washington response, what do we do? We come out with a reauthorization that expands the eligibility. Already we have in place a waiver where New Jersey can currently go up to 350 percent of poverty. Well, what is that? That is $77,175. Now in the reauthorization bill, we are going to grandfather the 350 percent, and we are going to go up to 400 percent for New York. What is 400 percent? Well, that is $88,200. How do those 5.4 million who were eligible before get enrolled? Well, the answer is, they are not. This is what Dr. COBURN was talking about. How about the kids nobody is going out to enroll? Do auto enrollment. It is easy.

But that is not what this bill is attempting to do. This bill is attempting to increase the eligibility to get a bigger slice of America eligible for Government programs so that at some point the number of folks who are on Government programs—Medicaid, Medicare, SCHIP, VA, the list goes on—is well over 50 percent of America, and then the die is cast. We go to a single-payer system. The Government runs it, the Government tells us how much we get, the Government tells us where we go, and the American taxpayer pays for everybody.

Now, here is the decision the Senate has—the House has already voted this bill out. We have a decision whether we are going to stand up for those 5.4 million. Those are the tough ones. Those are the ones who did not walk into the door and raise their hand when their parents were told they were eligible and say: I want to enroll. I would like health care. I would like prevention. I would like a primary care doctor. I would like a medical home. No, they are the 5.4 million children who are out there to whom no State is reaching out. They are just letting them fall by the wayside. Rather than focus on the 5.4 million, we are focusing on how we increase eligibility, how we change the income parameters.

Let me point out New Jersey, which is grandfathered to 350 percent of poverty under this bill, ranked 47th in the country at enrolling children who are at 100 percent to 200 percent of poverty. Let me say that again. A State that we have allowed to be grandfathered in at 350 percent of poverty ranks 47th out of 50 in the United States at enrolling kids between 100 and 200 percent of poverty.

As a matter of fact, 28 percent of their children are uninsured in that 100 to 200 percent of poverty. Yet once again we are going to grandfather them and allow this incredible expansion to continue. So where is their focus? Let's go after the easy ones. Let's go after the ones in families who are easier to find and who are easy to enroll.

Well, why does that happen? Let me point out to my colleagues, Medicaid gets a matching rate from the federal government, depending upon which State you are from, and that rate is from 50 percent to 75.9, with a ceiling of 83. So as the State makes a Medicaid payment of $1, depending upon what State you are from, the Federal Government reimburses anywhere from 50 cents to 83 cents.

But if you are enrolled in SCHIP, the range goes from 65 to 85. So if you are on the bottom, if you are a State on the bottom, why would you lobby for expanded eligibility? It is because if you are on the bottom, you are going to have an increase in the Federal share of what you pay out from 50 to 65 cents. It is 15 cents of every dollar. You are crazy, if you are a State, for not lobbying for this because you are going to spread the cost over the entire taxpayer base. It makes a lot of sense if your focus is not on 5.4 million children and how they get covered and how they get health care.

If you are only focused on how you get a bigger piece of the Federal pie, if you are only focused on how you get a bigger share of space at the trough, then this makes a tremendous amount of sense. But from the standpoint of developing health care policy, it makes absolutely no sense whatsoever.

I don't take my position just looking at one section of the bill. Dr. COBURN pointed out, as I did earlier, that the financing of this bill is suspect. In fiscal year 2012, which is the last of 5 years, we allocate $14.98 billion to fund the program, almost $15 billion. Yet in 2013, the bill reduces the allocation to $5.7 billion. How do you have a health care program for children, with all these people enrolled, that is sucking up $15 billion a year, and all of a sudden, the next year it drops to $5.7 billion? The answer is, you don't. We all know it. The reality is, you have to go to the next 5-year period to find the answer. The answer is, starting in year 6, out of the next 5-year budget, we do a one-time payment of $11.7 billion on top of what it costs us to run the program for 2013.

So what does that mean? Frankly, it means the accounting methods used in Washington are not accounting methods any family in America could use because their creditors would walk in the door and shut them down. Yet we get up here every day and claim we do things just like people at home. In fact, we know when it comes to budgets, there is no American family who can get away with what we get away with, especially when it is this obvious. One year it costs us $15 billion. The next year it costs $5.7 billion. There are only two ways you accomplish that. You either reduce enrollment drastically or you magically come up with the money and you stick it in and say: Oops, we didn't understand that was going to happen.

We understood it was going to happen. It is done to fit the parameters, to get around pay-go rules so you can actually take this money and stick it right onto the deficit and the debt of the country. In other words, we are going to provide our children health care with one hand, and we are going to rob their financial future with the other, all at the same time. It is miraculous that we would even attempt to do this. At least we could ask for honesty and transparency in how we are funding this program.

It is important that we sort of recap. What is SCHIP? I think a lot of people

who might not have been in Congress very long, certainly weren't here in 1996 and 1997 when we passed it, people across the country might be saying: I have never heard of this program. Again, we saw the need in 1996 to create an insurance product for children's health, for those people who financially didn't qualify for Medicaid and didn't make enough to purchase insurance on the open market. SCHIP was created with the vision of trying to take kids from 100 percent of poverty to 200 percent of poverty and make them eligible for a program where 100 percent of them would have health care. Nationally, the parameters grew from 100 percent to 300 percent, and we still haven't met the original 1996 mission of covering all the kids. Because with 5.5 million people covered today, average monthly number, we still have 5.4 million over here who are eligible and don't have insurance. Clearly, we have a tremendous amount of work to do to get the SCHIP program to fulfill its original mission.

Let me go specifically to the bill before us. CBO estimates the bill will increase outlays by $32.3 billion above the baseline over 5 years and $65 billion over 10. The cost is offset by a tobacco tax. I am from North Carolina. I can get up and wail about how this is unfair. It is not the first time Congress has done it. It is the most regressive tax there is. In essence, we are taking a group who financially are challenged and, according to every analysis I have looked at, the people who are going to be most taxed by a tobacco increase are those people in the lower socioeconomic levels. So, in essence, we are not spreading this across taxpayers. We are asking the parents of these children to pay for the expansion in eligibility because we are going to tax them for every cigarette they buy and consume. We are going to hope that they quit. When they quit, I am not sure how we are going to fund the program except probably do it the same way we are doing it in the year 2013. We will come up with the money in some way and some fashion.

It is important we realize today we have something we call a Medicaid sandwich. Medicaid starts here; SCHIP goes here; Medicaid wraps on the top. It is hard to believe we could have something designed that is so complicated for the States, that Medicaid applies here to some; SCHIP applies here to others; and Medicaid applies on top of that to an even larger group. If it seems confusing, it is. If it is this confusing, one has to ask: Why don't we change it? Why don't we fix it? Yet as I continue to go through the Baucus bill, what I find is that we are making it more complicated. We are designing it in a fashion that aggressively goes after an increase in enrollment but does not go after the 5.4 million children who currently today are unenrolled in the program but are certainly eligible. As a matter of fact, the Baucus bill spends $34 billion over 5 years. It targets 5.7 million new children. I might add, 2 million of those children today are currently covered under their parents' insurance. So we have actually got a net pickup of 3.7 million kids who were uninsured. That is $34 billion.

There is an alternative plan. It is called the McConnell substitute. It is called Kids First. It uses $19.3 billion over 5 years to enroll 3.1 million kids who are uninsured today. So what do we get with the $34 billion investment that we are not getting with a $19.3 billion investment? The answer is quite simple: 600,000 uninsured kids who are enrolled under the Baucus bill. When you do the simple math on that, you find out you are paying $4,000 per enrollee under the Baucus bill.

Now, I don't expect everybody to associate with this, but last year I had a son who was a senior in college. Because we have these funky Government rules that say no matter where you are in your education process, when you become 22, you are no longer eligible to be under Government insurance for your family—it doesn't apply just to Members of the Senate or to Congress; it applies to every Federal employee—I was forced, as a parent, to go out and go through the thought process of getting my son insurance. Sure, he is 22 years old. He is healthy as a bull. There is no reason I should suspect he is going to get sick. But what if something happens to him.

So I immediately did what every good Federal employee would do. I called the correct office up here, and I said: This has to be something you have run into. Have you got some type of gap insurance I can turn to and I can purchase for that 22-year-old healthy son? They said: Certainly, Senator. We have negotiated with the same company, the same plan he was under, and he can go on that tomorrow. I said: How much is that? They said: $5,400 a year, for a 22-year-old, healthy-as-a-bull senior in college.

I did probably what every parent would do. I called the college and said: Have you got a plan? Here is the situation. They said: Absolutely. We have negotiated with the same company, with the same plan he was under as a child of a Federal employee. I said: What is the premium? They said: $1,500 a year.

Now, that lesson I actually learned when I became a Member of Congress. When I became a Member of Congress, I chose the same insurance plan I was under in Winston-Salem, NC, working for a company of 50 employees, the same exact plan paying the same 25 percent, and the only difference was my health insurance cost went up $100. Why? Because a company of 50 employees negotiated a better plan than the U.S. Government on behalf of 2 million employees. But it had been 14 years. I had forgotten that. I relearned it firsthand though with my son, when all of a sudden I realized he got a plan for $1,500 that the University of North Carolina Chapel Hill had negotiated, and the Federal Government had negotiated the same plan at $5,400. No wonder parents are confused. No wonder most Americans are confused. What a screwed up market this is. How unbelievably complicated is it for an individual to try to go out and access insurance, and at what point do you actually know that you have found a value?

Let me try to bring some relevance to this story. For that 22-year-old, healthy-as-a-bull senior in Chapel Hill, his health care plan was $1,500 a year. For all these 600,000 kids we are adding to SCHIP, we are spending $4,000 a year to insure them. The average cost per policy for somebody under 18 in America today is about $1,132. Yet under the Baucus bill we are going to invest $4,000 per child, per those 600,000 children, to make sure they are covered—not a wise investment. But considering my experience with the Federal Government, I can understand why, for some people here, that makes absolutely perfect sense.

Let's assume for a minute somebody is going to say my numbers are wrong. I am sure they will before the debate is over. Let's assume for a minute we are trying to figure out the number of increased enrollees—and I am not talking about the ones who had their own insurance and we just shifted them over to government insurance—what are we paying for them? We are paying about $2,200. They are still paying $700 more a year to insure every child 18 and under than I paid in premiums to cover my 22-year-old, healthy-as-a-bull senior in college. So we are overpaying at least by $700. At most, we are overpaying by almost $2,500. Somewhere in that range, I would hope the American people would say: Hey, let's stop for a second. Let's call time out. Let's go back and get Congress to re-look at this program because this doesn't make a lot of sense.

I am not getting into any of the aspects that have already been addressed which deal with the loopholes that were created. I actually sat on the floor and heard somebody say this was a bipartisan bill. If you count one Republican vote out of the Finance Committee, then you are right, it is bipartisan. But I am not sure that is President Obama's interpretation of what bipartisanship is. He came to the Hill. He had lunch with us today because he is trying to get more Republicans to support a stimulus package because he doesn't want to just win it, and he doesn't want to win it by one vote. He wants the American people to understand that there is confidence up here in the legislation that is passed. He probably should have talked about this bill. It is going to be bipartisan, not by many votes.

If that is the type of bipartisanship we want, then it is going to be a long couple of years.

My hope is we can actually get something done. There are so many areas I

could talk about on this bill, but it would keep me here forever, and I see my good friend, Senator WHITEHOUSE, is in the Chamber.

Let me end with this. I am sure I will come back. What I want Members to search their souls and ask is, Is it really the Federal Government's responsibility and, more importantly, the taxpayers' responsibility that a family making $88,000 be included in a plan that is designed and was originally designed to take care of kids between 100 and 200 percent of poverty? Do we feel bad that today 5.4 million children who are eligible at 100 percent to 200 percent of poverty are not enrolled in the program?

This is not the first time I have had a test like this. My own President, last year, proposed we increase spending for HIV/AIDS patients in Africa from $15 billion to $50 billion, and to many people's amazement, TOM COBURN and I supported the President. Then all of a sudden they made a change in the program. The program had always said 50 percent of the money had to go to the treatment of HIV and AIDS patients, meaning they actually had to deliver medicine to them.

Well, when all of a sudden the countries that got these Federal grants to carry out these programs in Africa looked at the program, they said: My gosh, for us to get from committing $7.5 billion all the way up to $22.5 billion in delivering medicines to people who have HIV or AIDS, that is going to be tough. We are going to have to work to find these people. It is going to be dangerous in some cases for us to get drugs out.

What did the White House do? They dropped the requirement in total. They did not require one dime of that $50 billion to actually go to the delivery of drugs to HIV and AIDS patients. So what did we do? We held up the bill. We were taking flak from our own President because other people wrote a bill that was structured poorly. It actually did not accomplish what we set out to have with PEPFAR originally.

At the end of the day, they put back in the requirement of 50 percent, and today, for the multiple countries this applies to, we have a commitment that $22.5 billion is going to go to actually treat individuals who have HIV and AIDS—our original intent of the program. We just expanded it.

Now, we were not going to get there just by saying it is difficult, therefore we do not think we should do that. And we are not going to cover these 5.4 million kids who are eligible but not enrolled if we say: Do you know what. This is hard. And since it is hard, why don't you change the program so the eligibility is wider so we can get some of the kids who are out here in different income groups who are easier for us to enroll than for us to go and find the 5.4 million who are so hard to find.

Well, I am going to say to my colleagues, just like I said to my President: No. That is not what we intended to do. We put this program together to make sure the most at-risk kids in this country had health coverage, so they had a medical home. To suggest we are now going to change the parameters of this and allow a larger income pool to come in because it is hard to reach out and find these 5.4 million people, no; it is not going to happen. It may happen, but it should be as difficult at happening as it possibly can.

I look forward to the debate we are going to have. It is my hope we will have an opportunity to actually look at honest budget numbers that share with the American people exactly what this costs, that we can look at the eligibility requirements with predictability, understand who is going to have an opportunity to be enrolled, and, hopefully, at the end of the day, when a bill passes—whether we vote for it or not—that we can all look at it and say: There is a real chance that 100 percent of the kids at 100 percent to 200 percent of poverty have a real opportunity to be enrolled in this program. I fear without changes to this legislation that will not happen. We will not have fulfilled what we set out to do.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, I see my colleague and friend from Virginia, Senator WEBB, who is prepared to speak, and we will recognize him in just a moment.

I would note there would have been, by our estimates, 3.3 million children who would have been covered had the bill passed in 2007. That would have been one very good way to reduce the number of children in this country who are not protected by health insurance.

Mr. BURR. Mr. President, will the Senator yield for a question?

Mr. WHITEHOUSE. Of course.

Mr. BURR. Would any of those 3.3 million children have been in 100 percent to 200 percent of poverty?

Mr. WHITEHOUSE. As I understand it, the bill contained both funds and programs for outreach that would have supported the States in their initiatives to find the children who, because their parents were moving or for one reason or another, were eligible but had not entered into these State programs. So I think the answer to that question would be yes.

Mr. BURR. Let me suggest to the Senator—and I will not ask him to yield much longer—there was the same expansion of eligibility in last year's bill, so the likelihood is any increase in enrollment would have been spread across not just the 100 percent to 200 percent of poverty, but all the way up to the 400 percent of poverty.

Mr. WHITEHOUSE. I think the increase in enrollment would have spread wherever the program went. There are very few areas, as the Senator knows, where the eligibility level is 400 percent of poverty. In the vast majority of the country, in my State, for instance, it is well below that. It is a program that supports working families, that supports low-income working families, that makes sure their children get health care.

But for a number of reasons, probably the most prominent of which is people moving from location to location and not being registered with the local program, there are outreach requirements. I would be happy to work with the Senator on improving those outreach requirements in any way he wishes. But I think to hold the entire bill and his support—I think in this case we are estimating it will now reach 4.1 million children—hostage because of not having gotten the outreach better is a strategic mistake.

If your goal is to insure more children, then you should go about it by insuring more children. If the outreach is a problem, then we can happily make that better. But for outreach to be criticized, when it was President Bush who vetoed that bill, I am not sure how the distinguished Senator from North Carolina voted on that—

Mr. BURR. Mr. President, I would be happy to disclose to my colleague that I voted against the bill, for the same reasons that without changes I will oppose it this year because the eligibility requirement is being expanded.

As I said, and I thought fairly clearly, when you expand eligibility, you take the pressure off of making sure the enrollees come from the most at risk. It is my hope we can modify this bill. I am not embarrassed to be on the Senate floor and talk about the aspects of this legislation that I am unhappy with. But certainly I can count, and I know the majority can move this bill at any point they feel comfortable, and I am sure they will.

At the end of the day, it is my hope we will cover as many of the originally targeted children in that 100 percent to 200 percent of poverty as possible.

Mr. WHITEHOUSE. I understand the Senator from Virginia wishes to speak. I will simply respond before I yield the floor to Senator WEBB that I have had quite a number of years of experience with our Children's Health Program in Rhode Island, back to the years when I came in with Governor Sundlun in a bad economic crisis in Rhode Island—probably the largest percentage deficit in the State budget of any State ever recorded. Even in that very gloomy fiscal environment, Governor Sundlun insisted we build a statewide universal health care program that protected children.

SCHIP is very much in line with that. The people who have been working on that for these many years in Rhode Island—and I suspect it is the case in many other States—feel a real passion for trying to make sure children get health care, that they get the health care to which they are entitled.

So I am not sure the notion that by just putting more pressure on them, by just refusing to add any other children until they have done this, is really a productive or fair way to go about

reaching the children who have not been reached. What the bill does is provide outreach funds and empower these people who care so deeply about this issue to actually get out there and work harder to find them, have the additional resources to find people. From my work in law enforcement, my work with schools, my work on health care, there are a lot of people who live apartment to apartment, very hand to mouth, and it is a very significant challenge to keep up with them. The resources to do that, I submit, would be the best way to solve that problem, not holding one set of children hostage to providing health care for another set of children.

With that, Mr. President, I yield the floor for the distinguished Senator from Virginia.

The PRESIDING OFFICER (Mr. NELSON of Nebraska). The Senator from Virginia.

Mr. WEBB. Mr. President, I thank the Senator from Rhode Island, and I am here to speak in favor of this legislation. This is a very important piece of legislation. It is long overdue. I also would like to point out that I have an amendment I will offer.

I am very concerned about the way this legislation is going to be funded. We all have our own issues with respect to whether tobacco should be used or not used, but to fund an entire program based on a tobacco tax, I think, is not the way to go for a number of reasons. So I am offering an amendment that will help offset this highly regressive, 61-cent-per-pack increase in the cigarette tax that is being used to fund this bill, and to add on to the bill a tax on carried interest, which is the compensation that is received by hedge fund managers. This proposal would generate $11.2 billion in revenue over 5 years. Tobacco taxes would thus be raised by a more reasonable 37 cents a pack to make up for the shortfall between the revenue being generated by this amendment and the costs of the CHIP reauthorization.

Tobacco is already federally taxed at 39 cents per pack for the CHIP program. All 50 States and the District of Columbia also impose an excise tax on cigarettes above this tax. For instance, my State of Virginia adds 30 cents on top of the present tax. In these difficult times, many States, including Virginia, are considering an increase in their State excise tax.

So we would have, with the amendment I am going to offer, the 39-cent Federal tax that is already in place on a pack of cigarettes, an additional 37 cents—instead of an additional 61 cents—plus the State taxes on cigarettes; and a big proportion of this—all the Federal tax—going to fund a health program.

I would like to be clear that there is no question in my mind about the fact that we do need to reauthorize and expand this program. But I do not think it is a proper to fund this program on the backs of people who, for better or worse, smoke cigarettes. I am a reformed smoker. Many of my contemporaries in the Senate are reformed smokers. I am not encouraging anyone to smoke cigarettes. I hope you do not. I just believe although tobacco taxes are already a popular source of revenue, it does not change the reality that this tax is regressive.

We had a Congressional Research Service report brought to my office, and I am going to quote from it. It said:

> Cigarette taxes are especially likely to violate horizontal equity and are among the most burdensome taxes on lower-income individuals. Only about a quarter of adults smoke, and less than half of families have expenditures on tobacco. Tobacco is more heavily used by lower-income families than are other commodities, and is unusual in that actual dollars (in addition to the percent of income) spent on tobacco products decline in the highest income quintile.

My amendment will help soften the blow of the increase in the cigarette tax.

Let me provide some background on carried interest. A partner of a private equity or hedge fund receives two different types of compensation. First, hedge fund managers receive management fees that are linked to the assets they oversee. Second, they receive what is called ''carried interest,'' which is compensation based on the percentage of the profits generated by the assets they manage. Currently, carried interest is taxed at a capital gains tax rate. As noted by Peter Orszag, who is now a member of the Obama administration, in his 2007 testimony, many economists view carried interest as:

> Performance-based compensation for management services provided by the general partner rather than as a return on financial capital invested by that partner.

Given that carried interest is performance-based compensation, it makes sense to tax it as ordinary income. This compensation has been earned by many of the same people who helped bring about the present financial crisis. The Financial Times stated these managers ''have made fabulous sums in recent years.'' Given the need to pay for children's health insurance, it makes more sense to have these persons, who are better positioned to pay for it, pay a greater percentage of the cost.

When it comes to taxing carried interest as ordinary income, there is a wide acceptance in support of this proposal among thinkers and editorial writers across the country. The Financial Times itself editorialized ''this repair should be done at once.'' They made that statement 2 years ago.

I have a string of editorials that support the idea of closing this carried interest loophole as a matter of fairness. I ask unanimous consent they be printed in the RECORD at the end of my statement.

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

(See exhibit 1.)

Mr. WEBB. They include editorials from the Washington Post, New York Times, USA Today, the Philadelphia Inquirer. In fact, the Washington Post in 2007, in talking about this particular tax break, said this:

> The only mystery is why Senate Democrats don't have the good sense to grab on to this as their centerpiece domestic issue. It's hard to think of an issue that better taps into the public anxiety about the markets and the economy, the anger about income inequality, or the disgust with a political system that bends to the will of powerful interests.

The Washington Post continued:

> This is a make-or-break issue for Democrats. If they can't unite around this issue, then they aren't real Democrats and they don't deserve to govern.

The New York Times in 2007 talked about this issue, mentioning:

> With income inequality surging along with the need for tax revenue, supporters rightly conclude that it is untenable for the most highly paid Americans to enjoy tax rates that are lower than those of all but the lowest income workers.
>
> Congress will achieve a significant victory, for fairness and for fiscal responsibility, if it ends the breaks that are skewing the tax code in favor of the most advantaged Americans.

There are others and, as I mentioned, I will insert the full text of these editorials at the end of my comments.

I also should point out that our new President, President Obama, has supported throughout his campaign the idea of taxing carried interest as ordinary income.

So the choice is this: Do we help fund this program, which we all agree is critically necessary, with a well-deserved tax adjustment for some of those who are the most capable of absorbing a new tax, or do we take money exclusively from tobacco, causing people who in large part are in the same economic circumstances as the beneficiaries of this health insurance program to foot the bill?

Let's think for a moment about the irony of that. We are taxing a practice that we deem unhealthy in order to fund a health program, and we supposedly want this practice to go away, but if it goes away, we are not going to be able to fund our health program.

So we need to find a way to fund health care needs that is sustainable and fair, and a declining revenue source is not sustainable. I hope my colleagues will join me in supporting this measure, which will partially offset the cigarette tax that is a part of the bill. I again wish to express my strong appreciation to Chairman BAUCUS and to others, such as my colleague from Rhode Island, who have worked so hard on this bill and who work to help those in our system who are most in need of medical care.

With that, I yield the floor.

EXHIBIT 1

EDITORIALS SUPPORTING CLOSING PRIVATE EQUITY/CARRIED INTEREST LOOPHOLE AS MATTER OF FAIRNESS

[From the Washington Post, Sept. 9, 2007]

PRIVATE-EQUITY TAX BREAKS, A CALL TO BE UP IN ARMS

Even by Washington standards, the private-equity industry certainly went over the

top in conjuring up the economic woes that would befall the United States if their cherished tax breaks were taken away.

Pensioners would be destitute. Wall Street would pack up and move to Dubai. The hedge fund industry would disappear. Federal revenue would plummet. Entrepreneurial risk-taking would grind to a halt. And the urban underclass would slip even deeper into poverty.

And all that just because some of the richest people in the world would have to pay the same 35 percent tax rate on their income as dentists, lawyers and baseball players.

There is no mystery as to why the industry bothers to make these ridiculous and contradictory arguments—billions of dollars in tax windfalls are at stake.

The only mystery is why Senate Democrats don't have the good sense to grab onto this as their centerpiece domestic issue as they head into the 2008 campaign. It's hard to think of an issue that better taps into the public anxiety about the markets and the economy, the anger about income inequality, or the disgust with a political system that bends to the will of powerful interests. And if Republicans go through with their threats of a filibuster and a presidential veto, Democrats ought to put aside all other business and call their bluff.

This is a make-or-break issue for Democrats. If they can't unite around this issue, then they aren't real Democrats and they don't deserve to govern.

[From the Washington Post, July 13, 2007]

EQUITY FOR PRIVATE EQUITY; LEGISLATION TO RAISE TAXES ON FUND MANAGERS' INCOME

Investment partnership funds can be enormously profitable, highly secretive and lightly regulated. People tend to get suspicious.

As a result, government bodies periodically try to tamper with private equity firms, hedge funds, venture capital firms and the like. This largely unregulated industry does a lot to stabilize America's financial system by fostering innovation and bringing inefficient or undervalued markets closer to equilibrium, and most of these attempts to regulate or reconfigure the industry would be bad for the U.S. economy. But this time around Congress has proposed legislation that makes sense.

A House bill would set a higher tax rate for ''carried interest,'' the cut of profits typically awarded to fund managers at private equity firms and other investment partnerships. In these investment partnerships, a fund manager typically manages the investment made by himself and various limited partners, with the manager usually contributing about 1 percent of the investment. The fund manager then usually receives 2 percent of the assets he manages annually and 20 percent of the profits earned on the investment when it is sold. Even though this 20 percent cut makes up the bulk of the manager's compensation, and even though it is awarded for managing others' money, under current tax law this income is treated as capital gains rather than ordinary income. As a result, fund managers who make zillion-digit incomes from carried interest can be taxed at the same rate (15 percent) as a part-time janitor.

The House bill, sponsored by Sander M. Levin (D-Mich.), Ways and Means Committee Chairman Charles B. Rangel (D-N.Y.), Financial Services Committee Chairman Barney Frank (D-Mass.) and 13 other Democrats, would close this loophole for fund managers and treat their ''carried interest'' earnings as regular income taxable at the ordinary 35 percent top-income rate that high-earning employees in other industries must pay. The bill would not affect the other investors in these funds, nor would it affect the tax rate for profits that fund managers make on investments with their own money.

A Senate bill that also attempts to bring equity to the private equity industry would force investment partnerships that are publicly traded—right now, only a handful—to pay corporate income taxes. Support for the Senate bill has gained some momentum because of Blackstone Group's splashy initial public offering, one of the largest in history. The Senate's corporation-rather-than-manager-based solution seems less effective, however, because companies can easily move overseas (as many have already done), while individuals are less likely to do so. Investment partnerships can also simply choose not to go public.

Critics of the two bills argue that investment fund managers should be rewarded for taking high risks. But these fund managers, for the most part, are not risking their own money, and they're paid management fees during the duration of their partnerships, so they have steady incomes. Besides, plenty of risky industries don't enjoy comparable tax benefits. Income earned from managing an investment partnership fund should be treated just like the income earned for providing any other service.

[From the New York Times, June 25, 2007]

RAISING TAXES ON PRIVATE EQUITY

So much for the argument often made by managers of hedge funds and mavens of private equity that higher taxes would cripple their business.

The prospect of higher taxes did not dent, in the least, the initial public offering on Friday of the Blackstone Group, the giant private equity firm. The week before, a bill was introduced in the Senate to raise taxes on private equity firms that go public. On the day of the offering, a House bill was introduced that would raise their taxes, whether they're publicly traded or not.

And yet, Blackstone had a debut that was one of Wall Street's biggest, its thunder muted only by the announcement by its longtime rival, Kohlberg Kravis Roberts, that it, too, planned to go public.

The bills in Congress take aim at a provision of the tax law that has allowed private equity and hedge fund operators to pay a lower capital-gains tax rate of 15 percent, instead of the ordinary top income-tax rate of 35 percent, on the performance fees that make up the bulk of their huge paychecks.

With income inequality surging along with the need for tax revenue, the bills' supporters rightly conclude that it is untenable for the most highly paid Americans to enjoy tax rates that are lower than those of all but the lowest-income workers.

Fairness is not the only reason to change the rules. The private equity industry is on shaky ground when it claims that current practice is a correct application of the law.

Many of the firms' partners are not investing their own money in the various funds and ventures, and so have no direct risk of loss, the general test for claiming capital-gains treatment on one's earnings. Moreover, the tax rules in question were developed decades ago for enterprises that had passive investors to whom gains were passed along. Hedge fund managers and private equity partners are not passive. They're actively managing assets, and should be taxed accordingly as managers earning compensation.

The challenge now is to develop a single bill that can withstand the formidable lobbying efforts of the private equity industry to water it down.

To do so, the final bill should clearly apply to other firms where partners may also receive most of their pay as capital gains, such as oil and gas partnerships. It will also be necessary to narrow the bill, where appropriate. For instance, it could include a mechanism to allow some compensation to be taken in a form similar to incentive stock options.

Congress will achieve a significant victory, for fairness and for fiscal responsibility, if it ends the breaks that are skewing the tax code in favor of the most advantaged Americans.

[From USA TODAY, July 23, 2007]

WEALTH MONEY MANAGERS MAKE MORE, GET TAXED LESS

As many business executives, doctors, lawyers and other skilled professionals know, the top income tax rate is 35%. The top rate on dividends and long-term capital gains is 15%.

Whether it makes sense to tax the output of expertise and hard work at more than twice the rate of investment returns is debatable. But, for better or worse, that's the way it is.

Except, that is, when it isn't. Owners of companies, ranging from small real estate partnerships to multibillion dollar hedge funds and private equity firms, have devised a way to erase this distinction. Their managers pay 15% on their income by dressing it up as investment returns—even though they bear no investment risk or put none of their own money in play.

Nice work if you can get it. But in this case it constitutes a frontal assault on fairness. Why should such people pay only 15% when senior corporate executives pay 35% for making many of the same types of business decisions? More to the point, it's hard to see the logic (or the justice) in a school teacher or bus driver with taxable annual family income as low as $63,700 paying 25% when someone like Blackstone Group CEO Stephen Schwarzman can make nearly $700 million on the day his firm went public and pay at most 15%.

Congress is rightfully re-examining the issue. Reps. Sandy Levin, D-Mich., and Charles Rangel, D-N.Y., have a proposal. In the Senate, Max Baucus, D-Mont., and Chuck Grassley, R-Iowa, have a useful, if narrower, bill.

The practice they are seeking to ban or limit is a transparent ruse. Here's how it works using the example of a private equity firm: The partners raise capital from banks, pension funds and other large investors, which they use to buy companies and resell them. Their investors give them some direct compensation, which is taxable as income.

But most of the compensation comes in the form of an investment vehicle known as ''carried interest,'' which gives them a right to a portion of the profits they generate (typically 20%). That portion of the profit is taxed 15%, just as if they supplied 20% of the capital at the outset.

It's a creative practice, but with a result that says the rich get to write their own rules. That's not a new problem in the American tax system, but it is nevertheless repulsive. Income is income, or so you'd think.

Supporters of this scam argue that these money managers actually are risking their own investments. It's just not money, in their case, but their ''sweat equity,'' their time, their expertise. But the same could be said of the lawyer who takes a case on a contingency fee, the movie actor who negotiates a cut of the box office receipts, the financier who chooses to work for a firm known for paying enormous bonuses during good years. In most, if not all, of such cases, these people pay income taxes.

And so should partners in these exotic investment firms. More so because the tax

they avoid paying is money that has to be made up by people of lesser means—or borrowed from later generations by adding to the budget deficit.

These schemes add insult to injury at a time of increasing wealth concentration. It is time to end them.

[From the Philadelphia Inquirer, Sept. 19, 2007]

EQUITY MANAGERS' LOOPHOLE; BILLION-DOLLAR BREAKS

For years, a relatively few players in the corporate takeover game have benefitted from a tax loophole that costs the federal government billions annually.

Now a push is under way in Congress to tax these wealthy managers of private equity funds at the same income-tax rates as everyone else. Congress should end this unfairness in the tax code.

Most workers pay income taxes on a graduated scale, with marginal tax rates running from a low of 10 percent, to a high of 35 percent for the wealthiest wage earners. But managers of private equity funds, who usually do extremely well for themselves, pay only a capital gains tax rate of 15 percent on most of their income. That's because the tax code considers their wages ''carried interest,'' even though this compensation can run into hundreds of millions of dollars per individual. The preferential treatment can be worth millions of dollars to such a manager.

Rather than being taxed on compensation for services rendered, these managers are taxed as though they had invested a 20-percent stake in the fund. But, even though they sometimes gain equity stakes in the companies they buy and manage, they don't have capital at risk in the ventures. They're really being compensated for their expertise and effort.

This definitional fiddle creates a class of service provider that is taxed a preferential rate. Economist Greg Mankiw, former chair of the Council of Economic Advisers under President Bush, has said that carried interest should be taxed at the same rate as other compensation for such services. As it stands now, an executive in a financial-services firm is taxed differently from the manager of a private equity or a hedge fund.

There's no good reason why a person earning $200 million per year should pay a lower tax rate than a single worker earning $45,000 annually and paying 20 percent in taxes.

The loophole costs the Treasury several billions of dollars per year. The sum is small compared with the overall federal budget. But in a budget season in which Congress and the president are feuding over a difference of about $22 billion, such sums do matter.

Some argue that taxing these fund managers at a higher rate would harm ordinary investors, such as those enrolled in state employee pension plans, because the fund managers would demand higher compensation. But the evidence is slim. The liberal Center on Budget and Policy Priorities, a nonprofit think tank in Washington, said the impact on investors would be ''quite small.''

And this glaring inequity shouldn't be preserved on the presumption that a tiny fraction of it will trickle down to the folks already paying their fair share.

[From the Washington Post, Nov. 8, 2007]

NO PAY, NO PATCH

Nearly everyone wants to ''patch'' the alternative minimum tax. Not everyone wants to pay to do so. That is the challenge facing lawmakers as they race to install yet another temporary fix on the tattered federal tax system in time for the Internal Revenue Service to produce forms reflecting the change. How this job is accomplished will show whether congressional Democrats are willing to live up to the pay-as-you-go obligations they imposed on themselves when they retook control of Congress—and whether Republicans can regain any credible claim to being committed to fiscal discipline.

The alternative minimum tax was created in 1969 to dun a tiny number of the super-rich who managed to avoid paying any income taxes. Because the tax isn't indexed for inflation and because the 2001 tax cut lowered regular tax rates, the AMT, without adjustments, will affect millions of taxpayers who everyone agrees were never its intended targets. But exempting those millions will cost a lot in forgone revenue, money that the Bush administration has built into its budget numbers. Because fixing the problem is expensive and complicated, lawmakers have chosen for years to slap a Band-Aid onto it—and bill the cost to future generations. This year's model totals $50 billion, $76 billion when the cost of extending expiring tax provisions and other changes is included.

To its credit, the House Ways and Means Committee has produced an AMT patch whose costs are offset by other changes, including eliminating the carried-interest deduction that allows private equity and hedge fund managers to pay taxes at far lower rates than other wage-earners. This is far from a perfect solution: It would take 10 years of revenue to pay for the one-year patch.

It's preferable, though, to the approach of congressional Republicans and the Bush administration, which is to not offset the tax cut with new taxes or spending cuts. House Minority Leader John A. Boehner (R-Ohio) was illustrative of the irresponsibility. ''Tax relief pays for itself by creating more American jobs for more taxpayers to strengthen our economy,'' he said in a statement. Perhaps Mr. Boehner believes that the Tax Fairy will simply leave $50 billion under the IRS's pillow; there is no economic basis for his statement that ''tax relief pays for itself.'' Moreover, if Mr. Boehner doesn't like the way Democrats propose to finance the patch, what would he cut instead?

Republicans may not be the only obstacle to responsibility. Senate Democrats say they want to comply with the pay-go requirement, and there were hopeful signs last week from Majority Leader Harry M. Reid (D-Nev.). ''I'm not in favor of waiving pay-go rules,'' he said. ''I think we cannot waver on that.'' But Senate Finance Committee Chairman Max Baucus (D-Mont.) has been less definitive, saying only that he'd like to comply with pay-go to the extent possible; he has also not been eager to close the carried-interest loophole. Once the pay-go rule is ignored, though, lawmakers won't be able to discipline themselves in the future. This is a key test for the party that wants to wear the mantle of fiscal responsibility.

[From the New York Times, Nov. 8, 2007]

ALTERNATIVE TAX SHOWDOWN

The House and Senate are poised to vote on a vitally important tax bill that poses a test for each chamber of Congress. In the House, the vote on a short-term fix for the alternative minimum tax will test whether Democratic representatives have the courage of their convictions. In the Senate, the vote will test whether Democratic senators have any convictions at all, or just a belief in keeping the world safe for campaign contributors.

Under current tax law, 23 million taxpayers will owe the alternative tax for 2007, up from 4 million last year. The tax was originally intended to apply to multimillionaires. But most of this year's alternative taxpayers make between $100,000 and $500,000 and about a third make less than $100,000. They all have good cause to feel rooked and to expect help from Congress.

The challenge is the ''pay-as-you-go'' budget rule adopted when Democrats took control of Congress this year. New tax relief must be paid for, either by raising taxes elsewhere or by cutting government benefits like Medicare or Social Security that cover everyone who is eligible. The one-year cost of shielding millions of Americans from a tax they should not have to pay is $51 billion.

The House tax committee met the challenge, drafting a bill that provides the needed tax relief and plugs the resulting budget gap, mainly by raising taxes on private equity partners and hedge fund managers. The bill is good policy. The tax relief assuages justifiably aggrieved taxpayers. Tax increases on private equity firms and hedge funds rectify outdated rules that have allowed the very wealthiest to enjoy tax rates lower than those paid by middle-income Americans and, in some cases, to defer taxes indefinitely.

But key Democratic senators, among them New York's Charles Schumer, who is the main fund-raiser for Senate Democrats, are balking. They know they must provide alternative tax relief, but they don't want to tax private equity and hedge funds to pay for it. Their defense of the industries' morally indefensible tax breaks is tawdry. As The Washington Post reported yesterday, in the first nine months of 2007, as pressure built to dismantle the tax breaks, investment firms and hedge funds contributed $11.8 million to candidates, party committees and leadership political action committees. That's more than was given in 2005 and 2006 combined. More than two-thirds of that money went to Democrats.

The Senate's equivocating has rubbed off somewhat on the House. The bill is still expected to pass the House, as early as tomorrow, but some members have wondered aloud why they should support a tough measure if the Senate is determined to kill it.

The answer is that it is the right thing to do. The House bill holds true to the pay-as-you-go rule when doing so matters most, that is, when large sums and difficult trade-offs are at stake. It undoes a tax injustice. And maybe, just maybe, the money men in the Senate can be swayed by example.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. Mr. President, this week we have the chance in the Senate to provide health insurance to 4.1 million children in this country who now don't have it, to cover 11 million children total. All we have to do is the right thing and pass H.R. 2, the Children's Health Insurance Program.

I know the distinguished Presiding Officer from Nebraska and the distinguished Senator from Virginia, who has just spoken so eloquently, have shared the experience I have had in my home State of Rhode Island, and that is to travel around and hear personal stories from people whose lives and whose health have collided with our broken, dysfunctional health care system. Too often, families in this country can't afford to pay for the care they need. As our economic troubles worsen, that problem only grows more acute. Too often, they can't even get in to see a doctor. Too often, when they do receive care, it falls short in quality, in efficiency, in effectiveness, and in timeliness.

The crisis in our health care system affects all of us, but it is greatest and it is most tragic when it affects our children. That is why Congress created the Children's Health Insurance Program which for years has given millions of uninsured, hard-working American families access to health care for their kids.

The program has not only expanded health care coverage for children, it has encouraged States to be flexible, innovative, and responsive in meeting their families' health care needs. We come from 50 different States with 50 different sets of history, demographics, and economics, and as a result, the States come up with different programs. That is something to celebrate, not to bemoan. The program has safeguarded the vulnerable, it has united families, and it has invested in the future of our Nation. It is a special program of all the things that we do here.

The Children's Health Insurance Program means that children are more likely to receive medical care for common conditions such as asthma or ear infections. It means that children end up with higher school attendance rates, and that children have higher academic achievement. It means that children have more contacts with medical professionals. It means that children receive more preventive care. It means that children go to the emergency room when it is an emergency, and when it is not, they have someplace else to go that allows them and their families to stay out of those expensive urgent care settings. So as we have done for the past 2 years, this week we are working to pass legislation to ensure that every eligible uninsured child in America can get regular checkups when they are well and can get medicine when they are sick.

Not long ago, former President Bush denied children needed health care coverage by vetoing this legislation. But the American voters have spoken and we are in a new era in this country—a new era for peace of mind, for security, and for dignity for American children and for their families. With a new Congress and a new President committed to health care for all American families, I could not be more hopeful as we discuss this bill today.

I am especially proud to serve with my senior Senator, JACK REED of Rhode Island, and to support him in this fight. I have been in the Senate for 2 years now. Before I even got here, JACK REED was one of the most prominent, most ardent, and most determined fighters for our Nation's children. Frankly, it is in significant part due to his relentless work that we have come this far.

I am proud also to represent a State that has one of the lowest rates of uninsured adults and children in the Nation. It was not easy. Rhode Island worked hard over the past 15 years to achieve this success. It began with the RIte Care Program in 1993. In 2001, the creation of the Children's Health Insurance Program allowed Rhode Island to further reduce uninsurance rates in the State. I am proud to be on the team of former Governor Bruce Sundlun who turned 89 a few days ago. When he was Governor, he created the original RIte Care Program. His vision and determination to do this, in a time of grave economic straits for Rhode Island, has yielded immense rewards. Now, as health care costs skyrocket and the number of people in this country who lack health insurance approaches the staggering number of 50 million—50 million Americans, and so many of them children—we in Congress have an obligation to strengthen initiatives like RIte Care through which States have made health care more accessible.

Today, 4.1 million uninsured children are waiting for us to pass this bill; 4.1 million children who might not see a doctor this winter when they get the flu because their parents can't afford to pay out of pocket for the visit; 4.1 million children who might delay needed vaccinations or other preventive care because their parents have to buy food instead; 4.1 million children who might not get an inhaler or insulin or—heaven forbid—chemotherapy because in this economic downturn, the money just isn't there.

Who could say no to uninsured, vulnerable children? Should we not at least be able to agree on that? Why would anyone say no? We plan to raise taxes on cigarettes, a tax that the American Cancer Society says could prevent nearly 1 million deaths and keep nearly 2 million children from starting to smoke; a tax with health savings that could ultimately decrease government costs for government health care programs; a tax that the Congressional Budget Office confirms will fully offset this bill so as not to add to our deficit. I don't think that would be a good reason to deny vulnerable children the safety and security of health insurance.

During the course of this discussion, some Members have tried to make this debate about illegal immigration. It is not. We should not permit the very difficult issue of illegal immigration to affect this bill to deny millions of children the health care they badly need. That would be a grave mistake. That would be a wrong.

Let me be very clear: Only children who are legally in the United States are eligible to receive coverage under Medicaid or the Children's Health Insurance Program. They must document their immigration status. Medicaid agencies use information provided by the Bureau of Citizenship and Immigration Services to confirm the status of legal immigrants applying for benefits. Further, this bill does not even require States to cover legal immigrant children. It simply provides and supports that option.

Legal immigrants pay taxes, they serve in our Armed Forces, and just like the rest of us, they play by the rules. They are our future citizens, and insuring their children makes sense. This was the law until 1996 when sweeping restrictions affecting legal immigrants were made. Since 1996, we have become wiser, and many of those restrictions have been reversed on a bipartisan basis by Congress. The provision in this legislation covering legal immigrants is fully consistent with that trend back to 1996 levels.

This Nation is slowly emerging from a dark time when our ideals and our virtues were too often hidden in the shadows, when we let our fear overcome our principles and our better judgment, when we lost sight of our priorities and left millions of people in the cold and millions of children uninsured. That time can end now.

This bill is a chance to show these millions of Americans that we have heard them and that we stand ready to help. We know how tough it is for working families in this economy. If there is one worry, one burden we can take off those parents' shoulders so they can be sure their children have the health insurance every American deserves, we should stand ready to help. This country should once again own its duty to protect those who cannot protect themselves and to restore dignity and hope where it has diminished.

I close by applauding Chairman BAUCUS and the Finance Committee for bringing this vitally important and long overdue legislation to the floor.

I urge all of my colleagues—it would be wonderful if we could do this together—to allow these 11 million children to be covered by health insurance, to have access to the health care they need, to grow up healthy and strong and ready to seize the boundless opportunities that are at the heart of the American dream.

I think we will find in the months and in the years ahead that there will be things we cannot do to help families. I know everybody in this Chamber wants to do everything they can, and we want to work as hard as we can, but the economic situation is dire, and we are not going to be able to do everything we would like. But this is something we can do. This is something we can do for American families and for their children, and I hope very much we will do it.

I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

COMMITTEE ASSIGNMENTS

Mr. REID. Mr. President, in accordance with S. Res. 18, I announce that the following Democratic Members have been assigned to the following committees: Agriculture, Mr. BENNET and Mrs. GILLIBRAND; Banking, Mr.

BENNET; Environment and Public Works, Mrs. GILLIBRAND; Foreign Relations, Mrs. GILLIBRAND; Homeland Security, Mr. BENNET; Aging, Mr. BENNET and Mrs. GILLIBRAND.

The PRESIDING OFFICER. The RECORD will show the appointments.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

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

Mr. REID. Mr. President, I ask unanimous consent that, at 5:25 p.m. today, the Senate resume consideration of the DeMint amendment, No. 43, with the time until 5:45 p.m. for debate with respect to the amendment, with the time equally divided and controlled in the usual form, with no amendment in order to the amendment prior to a vote; that at 5:45 p.m. the Senate proceed to vote in relation thereto; that upon disposition of the DeMint amendment, the Senate resume consideration of the Hatch amendment, No. 45, with 2 minutes of debate equally divided and controlled prior to a vote in relation to the amendment, with no amendments in order to the amendment prior to a vote; that upon disposition of the Hatch amendment, the Senate proceed to executive session and the Banking Committee be discharged from further consideration of the nomination of Daniel K. Tarullo to be a member of the Board of Governors of the Federal Reserve System; that the Senate then proceed to vote on confirmation of the nomination; that upon confirmation, the motion to reconsider be laid upon the table, and the President be immediately notified of the Senate's action; that the Senate then resume legislative session; further, that after the first vote in this sequence, the remaining votes be 10 minutes in duration.

If I could say to Senators within the sound of my voice, we would be having more votes today, but I conferred with Senator MCCONNELL. The Finance Committee is involved in marking up the economic recovery plan. There are scores of amendments they are trying to work through so we are limiting the number of amendments today. We are going to work hard tomorrow, as I indicated when we opened today. We are not going to have morning business all week. We are going to get these amendments processed as quickly as we can.

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

Mr. WHITEHOUSE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. WHITEHOUSE. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mrs. MCCASKILL). Without objection, it is so ordered.

Mr. WHITEHOUSE. Madam President, I see the very distinguished Senator from Arkansas in the Chamber to take over managing this bill.

Before I leave the floor, I want to make two points. I have been here while a great deal of discussion has taken place about 5.4 million children who are eligible for children's health care but who, through lack of effort, it is claimed, the State programs are not finding. The purpose of the argument has been to argue if we could make the States find these kids, they would be the ones for whom the program was truly designed, and that the 4.1 million additional children we are going to help with this legislation are sort of a distraction from that figure.

I have not been able to source that 5.4 million number to anything. I would note on a population basis, my State of Rhode Island is one three-hundredth of the country. So if there are 5.4 million kids out there, in that circumstance, Rhode Island should have, by my math, 18,000 of them. We only have 12,000 kids in the CHIP-funded portion of what we call the RIte Care Program.

From my own experience, the likelihood of there being 18,000 eligible children in our small State who cannot be found makes no logical sense at all, which gives me significant pause about the validity of this 5.4 million number upon which so much of our colleagues' argument stands.

The other point I would make is there are many States that could reach more eligible children, but the funding is not there for them. Rhode Island is one such State. When other States return funds, we get access to that pool, and we can expand our coverage.

So, in fact, by supporting this legislation, you will enable the State programs to reach whatever that group of kids is, whether it is 5.4 million or 540,000. I do not know what the number is. Madam President, 5.4 million sounds very unlikely. But even setting that question aside, the fact that we would vote against this piece of legislation in order to help those 5.4 million kids makes no sense whatsoever because this legislation contains both the funding and the outreach tools to allow the State programs to reach those very kids.

So that argument, at least from this Senator's perspective, appears to hold no water whatsoever, or at least requires substantially better justification and support before it should be counted on, at least in my view, by any Senator as a reason to oppose this piece of legislation.

With that observation, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DEMINT. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

AMENDMENT NO. 43

Under the previous order, the time until 5:45 will be equally divided and controlled prior to a vote on amendment No. 43, offered by the Senator from South Carolina, Mr. DEMINT.

The Senator from South Carolina is recognized.

Mr. DEMINT. Thank you, Madam President.

I wish to take a few minutes to talk about an amendment I am offering as part of the children's health plan we will be voting on probably later this week.

I think it is important, as we talk about expanding the program, we do it responsibly and make sure we do everything we can to keep personal responsibility as part of the plan. All of us, Republicans and Democrats, look forward to the day when every American family has a health insurance plan they can afford and own and keep.

The children's health plan is, I see, maybe an interim step to that. It was started to help America's poorest children be insured. The plan we are discussing today, however, expands the children's health plan to children over 200 percent of poverty. One of the things we want to make sure does not happen is people who have private insurance and have taken responsibility for health insurance for their family are not encouraged to drop their private insurance and to join a government children's health plan.

There are ways we can do it, and some States already do this. This is by adding cost-sharing provisions for those who take advantage of the government children's health plan. That is what my amendment is about: making sure States that provide Government health coverage to families over 200 percent of poverty have some cost-sharing arrangement to send the signal that this is not a permanent subsidy from Government but a temporary bridge to help families who need some help getting health insurance for their children to get the help they need.

So let me talk a little bit about what is in there.

Again, the main goal of this amendment is to stop the people moving from private plans—that they are paying for and taking responsibility for—to a Government-sponsored plan so there is accountability, and that is what we want to make sure is in this system.

We need to remind our colleagues the children's health plan was created for America's poorest children. I wish a lot of our emphasis and debate was on: How can we get more children under 200 percent of poverty actually registered for the program? There are millions of children today who qualify for the current children's health plan who are not registered, either for what we call SCHIP or for Medicaid. Instead of

just taking those numbers up and expanding the people who can take advantage of the program, we should be trying to get those who are most needy registered for the program. Instead, I am afraid we are going to crowd out those folks, as we provide insurance for other families. In some States, under this plan, families making over $70,000 a year, with a family of four, can take advantage of Government health plans.

So what we are going to have is one person making $70,000 a year paying for their own private insurance and their neighbor making the same amount who has Government health care. There are ways we can discourage it. A number of States already require that the beneficiaries of this children's health plan pay a copay or a small part of the cost of the health insurance, and that is what this amendment does.

My amendment specifically would require that States that are offering the children's health plan to families above 200 percent of poverty have some minimum cost-sharing. We protect the beneficiaries by saying that no State can charge a user of the children's health plan more than 5 percent of their monthly income, and we don't have a minimum. So we expect most States to have a very minimum cost-sharing plan put in place.

What we are doing does not replace or change anything that States already have set up for cost-sharing. In fact, I think it will make it fairer for them. The way the system will work, unless we pass this amendment, is the people in States that are participating in the costs of this plan will help pay more for those States that don't have any cost-sharing. So it is not fair, if we have some States encouraging personal responsibility and cost-sharing, to put more of a burden on them to pay for States that might not do the same.

My belief is that every State would implement for families over 200 percent of poverty a cost-sharing arrangement. What this does is just lays out some basic parameters that give the States complete flexibility, whether it is a copay, whether it is a percent of the insurance, but not to exceed 5 percent of the income of any of the recipients.

I understand this is the next amendment to be voted on. I encourage all of my colleagues to do everything we can to stop any incentives that move people from private insurance to Government insurance, create some accountability and personal responsibility in this plan for the ones with higher incomes, and to save more of the dollars for those who are most needy in the plan.

Again, I encourage a vote, and I reserve the remainder of my time.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. PRYOR. Madam President, I ask unanimous consent that the time during the quorum call be divided evenly, and I suggest the absence of a quorum.

Mr. DEMINT. Madam President, reserving the right to object, I understand I have 2½ minutes left; is that correct?

The PRESIDING OFFICER. That is correct.

Mr. DEMINT. And the quorum call will be applied against that time; is that correct?

The PRESIDING OFFICER. Equally applied to the Senator 2½ minutes and the time remaining on the majority side.

Mr. DEMINT. If the Senator would agree, I don't have much time left, and if I could reserve that time. If there is no opposition, obviously, I don't need to use any additional time.

Mr. PRYOR. That is agreeable.

Mr. DEMINT. I thank the Senator.

Mr. PRYOR. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. PRYOR. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. PRYOR. Madam President, I move to table the DeMint amendment No. 43 and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Massachusetts (Mr. KENNEDY) is necesarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Louisiana (Mr. CHAMBLISS).

The PRESIDING OFFICER (Mr. TESTER). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 60, nays 37, as follows:

[Rollcall Vote No. 16 Leg.]

YEAS—60

Akaka	Feingold	Mikulski
Baucus	Feinstein	Murray
Bayh	Gillibrand	Nelson (FL)
Begich	Hagan	Nelson (NE)
Bennet	Harkin	Pryor
Bingaman	Hutchison	Reed
Bond	Inouye	Reid
Boxer	Johnson	Rockefeller
Brown	Kaufman	Sanders
Burris	Kerry	Schumer
Byrd	Klobuchar	Shaheen
Cantwell	Kohl	Specter
Cardin	Landrieu	Stabenow
Carper	Lautenberg	Tester
Casey	Leahy	Udall (CO)
Collins	Levin	Udall (NM)
Conrad	Lieberman	Warner
Dodd	Lincoln	Webb
Dorgan	Menendez	Whitehouse
Durbin	Merkley	Wyden

NAYS—37

Alexander	Cochran	Graham
Barrasso	Corker	Grassley
Bennett	Cornyn	Gregg
Brownback	Crapo	Hatch
Bunning	DeMint	Inhofe
Burr	Ensign	Isakson
Coburn	Enzi	Johanns
Kyl	Murkowski	Thune
Lugar	Risch	Vitter
Martinez	Roberts	Voinovich
McCain	Sessions	Wicker
McCaskill	Shelby	
McConnell	Snowe	

NOT VOTING—2

Chambliss	Kennedy

The motion was agreed to.

AMENDMENT NO. 45

The PRESIDING OFFICER. Under the previous order, there will now be 2 minutes of debate equally divided prior to a vote in relation to amendment No. 45, offered by the Senator from Utah, Mr. HATCH.

The Senator from Utah is recognized.

Mr. HATCH. Mr. President, to remind my colleagues, the Hatch amendment, No. 45, says that before a State is permitted to cover legal immigrants through CHIP and Medicaid, it must demonstrate to the HHS Secretary that 95 percent of its State children who are citizens under 200 percent of the Federal poverty level are enrolled in either the State's Medicaid Program or CHIP.

My amendment does not prohibit legal immigrant children from being covered, but it does set some of the parameters. Again, I believe our U.S. children who are citizens should be covered first. If you cover 95 percent, then you can go on and do more. Once those kids are covered, I am happy to work with my colleagues to cover legal immigrant children, but our U.S. citizen kids should be covered first. That is all I am saying, and I think it is reasonable.

Mr. President, I think this is a reasonable amendment. I am prepared to ask unanimous consent to have a voice vote on it.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, basically the amendment requires States to certify that 95 percent of their CHIP children, or Medicaid, are being paid first before the children of legal immigrants. No State meets that requirement.

I might also say the nationwide average for covering children under 200 percent of poverty is 80 percent. No State reaches 95. It is too high a standard.

More than that, we do include in this bill provisions for bonus payments to States to encourage them to cover low-income kids first. I think it would be inappropriate and unfair to make it an ironclad requirement that States must certify 95 percent. These are kids who are sick through no fault of their own. Their parents are paying taxes. They are full citizens—they are legal immigrants, but they are already incorporated into the system, being taxed, et cetera, and their kids should not be penalized.

I strongly encourage us not to adopt this amendment because no State can certify to 95 percent.

The PRESIDING OFFICER. All time has expired. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I ask unanimous consent that we withdraw the call for a rollcall vote and voice-vote this amendment.

The PRESIDING OFFICER. The rollcall vote has not been ordered.

The question is on agreeing to the amendment.

The amendment was rejected.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. REID. Mr. President, I have conferred with the Republican leader. This will be the last vote today. The Finance Committee is still meeting, and they expect to continue working tonight. I spoke to the chairman just a short time ago. He is going to do everything within his power to finish the markup tonight. We are going to get back tomorrow and again have no morning business. We will be back on this bill tomorrow. Everyone who has amendments to offer, get them ready.

EXECUTIVE SESSION

NOMINATION OF DANIEL K. TARULLO TO BE A MEMBER OF THE BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

The PRESIDING OFFICER. Under the previous order, the nomination is discharged and the Senate will proceed to executive session to consider the nomination, which the clerk will report.

The bill clerk read the nomination of Daniel K. Tarullo, of Massachusetts, to be a member of the Board of Governors of the Federal Reserve System.

Mr. LEVIN. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There appears to be a sufficient second.

The question is, Will the Senate advise and consent to the nomination of Daniel K. Tarullo, of Massachusetts, to be a member of the Board of Governors of the Federal Reserve System. On this question, the yeas and nays have been ordered and the clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Massachusetts (Mr. KENNEDY) is necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Georgia (Mr. CHAMBLISS).

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 96, nays 1, as follows:

[Rollcall Vote No. 17 Ex.]

YEAS—96

Akaka	Boxer	Coburn
Alexander	Brown	Cochran
Barrasso	Brownback	Collins
Baucus	Burr	Conrad
Bayh	Burris	Corker
Begich	Byrd	Cornyn
Bennet	Cantwell	Crapo
Bennett	Cardin	DeMint
Bingaman	Carper	Dodd
Bond	Casey	Dorgan
Durbin	Kyl	Risch
Ensign	Landrieu	Roberts
Enzi	Lautenberg	Rockefeller
Feingold	Leahy	Sanders
Feinstein	Levin	Schumer
Gillibrand	Lieberman	Sessions
Graham	Lincoln	Shaheen
Grassley	Lugar	Shelby
Gregg	Martinez	Snowe
Hagan	McCain	Specter
Harkin	McCaskill	Stabenow
Hatch	McConnell	Tester
Hutchison	Menendez	Thune
Inhofe	Merkley	Udall (CO)
Inouye	Mikulski	Udall (NM)
Isakson	Murkowski	Vitter
Johanns	Murray	Voinovich
Johnson	Nelson (FL)	Warner
Kaufman	Nelson (NE)	Webb
Kerry	Pryor	Whitehouse
Klobuchar	Reed	Wicker
Kohl	Reid	Wyden

NAYS—1

Bunning

NOT VOTING—2

Chambliss Kennedy

The nomination was confirmed.

The PRESIDING OFFICER (Mr. UDALL of Colorado). Under the previous order, the motion to reconsider is considered made and laid upon the table.

The President will be immediately notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will resume legislative session.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009—Continued

The PRESIDING OFFICER. The Senator from Ohio.

ECONOMIC RECOVERY

Mr. BROWN. Mr. President, the severity of this economic crisis requires the Federal Government to respond quickly and forcefully. The economic recovery proposal we are considering has two key objectives: stimulating the economy and creating jobs. Congress currently is negotiating where the funds will be spent—on infrastructure projects, on health care and safety net programs, on developing alternative energy for the 21st century economy. As we decide how to spend these tax dollars, it is imperative we consider where to spend them or, rather, on whom. These funds must create American jobs. To do that, we must ensure that Federal funds are used to buy American services and American products.

Our economy is suffering from the highest unemployment rate in more than a decade and a half. In 2008, we lost 2.6 million jobs, the largest job losses in 1 year in more than six decades. Our unemployment rate jumped to 7.2 percent. We all know that number doesn't tell the real story, the real human story. The more accurate measure of joblessness, the unemployed and the underemployed, or workers whose hours have been cut, is almost 14 percent. More than 533,000 jobs were eliminated in December. Yesterday, some of America's strongest, most prestigious companies announced more than 55,000 job cuts in 1 day. Among them was General Motors, which announced it would cut a shift at its Lordstown plant in Mahoning County in northeast Ohio. As President Obama said:

> These are not just numbers on a page. There are families and communities behind every job.

Communities such as Moraine and Chillicothe and Canton understand what happens when there is a major layoff. They don't need to hear the new job numbers. They understand it when small businesses close and diners empty out.

Manufacturing jobs keep American communities strong, and the steepest job losses are occurring in manufacturing. Nearly one in four manufacturing jobs has simply vanished since 2000, and 40,000 factories have closed in the last 10 years. Last year, manufacturing accounted for nearly a third of all lost jobs, while factory orders plummeted to record lows. Inventories are piling up because no one is buying. This leads to production cuts and then massive job losses that we will likely see more of this year. President Obama said it is likely going to get worse in 2009 before it gets better.

A loss of manufacturing is about more than jobs; it is about the loss of the Nation's middle class. I want to lay out what exactly the benefits of manufacturing are to this Nation.

Many of us represent large manufacturing workforces. All of us represent some manufacturing, some in more States than others. We all recognize or all should recognize the importance of manufacturing to our national security and to our domestic security—for families, neighborhoods, communities, for the Nation.

Let me cite the benefits of manufacturing:

No. 1, these jobs pay better on average than others.

No. 2, manufacturing jobs have a stronger multiplier effect, supporting as many as five other jobs. For instance, an auto assembly plant obviously creates other jobs—suppliers and tool and die shops and machine shops and parts manufacturers, and all that those jobs create. Manufacturers are large taxpayers supporting vital public services and schools in communities across the Nation.

No. 3, if you have a large industrial plant in a school district, that school district gets an awful lot of help in local property tax dollars from the manufacturing plant.

No. 4, American manufacturers are on the cutting edge of new technologies in the clean energy economy of tomorrow.

No. 5, if we are to end our dependence on foreign oil, we need to do more manufacturing here rather than allowing it to go offshore, especially in alternative energy.

No. 6, our national security depends on a strong defense industrial base to supply troops and protect our national interests.

Without a bold economic recovery plan that makes manufacturing a priority, the job losses will continue throughout this year and into next.

''Buy American,'' established in 1933 by President Roosevelt, requires that Federal purchasers prefer U.S. products. In other words, if the product is made in the United States at a decent price, then Federal purchasers must buy those products. But over the years, waivers of those preferences have been abused to create giant loopholes in ''Buy American.'' In other words, when we should be buying American, we are often buying Chinese or from some country in the European Union or Mexico. U.S. tax dollars whenever possible should go to create U.S. jobs. It is pretty simple. It is something people at home simply don't understand—nor do I—why we, as a country, as a government, don't use our tax dollars to create American jobs.

I am concerned about the lack of transparency in the waiver process and how that can lead to lost business, lost jobs, lost work, the actual steel, iron, cement, and other materials coming from overseas and not creating jobs in our country.

The Obama administration's stated goal is to make the biggest investment in the Nation's infrastructure since President Eisenhower created the Interstate Highway System more than 50 years ago. Imagine all this infrastructure, steel, concrete, all the materials we are going to buy with tax dollars, what it will matter if these products are made in the United States and not somewhere else. That is what we did mostly with the Interstate Highway System 50 years ago.

So when we are building infrastructure, whether it is water or sewer lines in Denver or whether it is a bridge in Minneapolis, this ''Buy American'' provision says we should be buying American and creating jobs here.

We have a responsibility to taxpayers to ensure that these dollars are creating jobs. Inclusion of ''Buy American'' requirements in the recovery proposal would be the most effective way to ensure that tax dollars are spent in the United States to create jobs. We have a responsibility to give American manufacturers the opportunity to bid on the steel and the iron and the other products that will be in demand from these massive investments in our infrastructure.

We have ''Buy American'' provisions in Federal statutes that provide that preference to use domestic materials, such as steel and other products and components, in federally funded highway and transit projects for State and local authorities. These need to be applied to the maximum extent possible as we try to revive the economy, as we move the Obama stimulus package through the Chamber.

Just last week, the Government Accountability Office reported on the benefits of Buy American policies. This is what the GAO said:

> The types of potential benefits to this program include protecting domestic employment through national infrastructure improvements that can stimulate economic activity and create jobs. . . .

This recovery proposal is about creating direct jobs with taxpayer dollars and then spin-off jobs with taxpayer dollars.

Let me be clear. This is not about stopping or slowing international trade. It is about using provisions in U.S. law consistent with our international obligations that allow for a preference for domestically produced goods financed by our U.S. taxpayer dollars.

Only if we do this will the recovery effort have the impact our towns and cities so desperately need. Why spend tens of billions—no, hundreds of billions—of dollars for infrastructure if we are not going to spend that money on American made products to create jobs directly and the spin-off jobs that come from that manufacturing?

American taxpayers deserve no less. Congress must act in good faith to create the most jobs here, especially in manufacturing. Enforcing the Buy America requirements already on the books and, to the extent we can, applying them to this stimulus bill is simply the right thing to do.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. CASEY. Mr. President, I rise tonight to speak of the Children's Health Insurance Program and the debate we are having in the Senate.

I appreciate what my colleague from Ohio just spoke of, the tremendous trauma that has been caused across the country with this terrible recession so many families are living through. I appreciate the fact he reminded us about what has been happening in our States and our communities as a result of this economic horror that so many families are living through. That horror and that trauma will only be increased in the months and years ahead if we do not pass this children's health insurance legislation. I think it is directly related to what we are talking about here when it comes to the terrible recession so many families are living through.

So I want to speak about the bill and deal with some of the questions that have been raised about the bill. But in particular, I want to, first, step back from the bill, from the debate, even step back for a few minutes from the program itself, to reflect on what the reality is for families.

I think when we speak of families and children's health insurance we speak and we think mostly about parents and the relationship they have to their children and what they want for their children. They, of course, want their children to succeed in life. They have hopes and dreams for their children. But, of course, for a parent, and especially for a mother, who is often providing most of the care for a child, her initial hopes, her initial fears, her concerns at the beginning of that child's life are very basic: Will that child be born healthy? Will that child grow and develop as he or she should?

I was thinking back to 2007 when we were having this debate at that time, thinking of the love of a mother and what she can provide for a child, especially a very young child. That mother can provide all of the protection she can muster for that child, she can envelop or embrace that child with protection and love and nurturing and all the wonderful things that a mother—a parent but especially a mother—can provide for a child. But there are some things that no matter what that mother does, no matter how much she loves her son or her daughter, there are some things she cannot provide on her own. She cannot provide health insurance on her own. She cannot provide medical care if she is not trained in that profession as a doctor or a nurse.

So there are a lot of mothers out there who have children they worry about every day of the week. They go to bed worrying what if that child has a problem in the middle of the night or some kind of a health care challenge in the middle of the day, what will happen to that child?

So when we are thinking about this debate and this issue, we should think about the love of a mother and what she can and cannot provide. That is one of the reasons why as a country we come together to solve problems such as this. We know an individual person cannot build a road, so we come together and provide public resources to build a road. We know one person or one family cannot provide law enforcement protection, so we all contribute to that. The same is true on health care. No matter how much that mother loves her child, she cannot on her own provide health insurance.

So what did we do? We created a program which in my State of Pennsylvania is called the Children's Health Insurance Program—CHIP for short. The program ''name'' is kind of redundant because the last word of the acronym is ''Program.'' But the CHIP Program then developed into a national program, as the Presiding Officer knows from his time in the House of Representatives, the so-called SCHIP, State Children's Health Insurance Program. That is what the debate is about.

What did we do? We created a program which now covers 6.7 million American children, most of whom, probably the overwhelming majority of whom would not have any health insurance coverage because, as we know, these are families who are above the income levels for Medicaid but they are often below or outside the category of families who have employer-sponsored health insurance. So they are in that gap: lower middle or middle-income families, in many cases. So we have covered 6.7 million children. That is wonderful. The only problem is there are millions more who are not covered.

This bill—strip away all the debate, all of the back and forth, all of the fighting about this—at its core, just as it did a couple years ago, is to provide health insurance to more than 4 million additional children. So 6.7 million, roughly, and you add 4.1 million, that is what you are talking about.

So we have the program in the legislation now to cover more than 10.5 million American children. Few, if any, generations of Americans who have served in a legislative body could say they cast a vote to cover that many children. It is a tremendous opportunity for a child, for their family, for the community and neighborhood they live in, for their State, and for their country now and in the next months and years ahead, but it is also important to all of us down the road.

Who would you want to hire 20 years from now? A child we invested in? A child who had health care in the dawn of his or her life? A child who had early learning opportunities? A child who had a good healthy start in life? I think as an employer you would want to hire a person who had that investment. They are bound to be more productive. So there is a long-term workforce argument. But even if that argument was not there, this is the right thing to do for the obvious reasons.

Now, what are we talking about? We are talking about health care and benefits. There is a long list of benefits I won't go through. We have charts we have all pointed to, and we will continue to do that.

But just consider one aspect of the benefits, one that I focus on because I think it is crucial to the life of a child and crucial to their—I should say, not just crucial, determinative of the kind of future they are going to have or not have, and that is well-child visits. One of the benefits that is covered in Pennsylvania is that in the first year of the life of that child he or she will get six well-child visits. Every child in America should have that opportunity. Every family should have the peace of mind to know that if all does not go well, at least their child has health insurance, and in the first year of their life they have been to the doctor at least six times, and they have been to the dentist and any other specialty they can get to and that the benefits cover.

So if we want to just focus on one benefit of the children's health insurance: a kid gets to the doctor six times in a year—pretty important. I am not a doctor, but we all know the benefit, as parents and as legislators from our work.

Another aspect of this legislation that does not get a lot of attention: When people hear about a government-inspired initiative, or a program in this case, that is partially paid for with public dollars, we often hear about: Well, that is just for communities where people are low income, but they are covered by Medicaid, so why do we need to help them? It does not help people kind of across the length and breadth of the country. It is somehow targeted to one group and, therefore, it is not good for everyone.

Well, I just made the case about the workforce long term. But one aspect of this issue in terms of a group of children who are often not in the headlines but benefit directly and are reliant upon the Children's Health Insurance Program and the Medicaid Program for children is that a lot of poorer families with children are in rural areas—people who live in rural areas across the State of Pennsylvania and across the country.

In my State of Pennsylvania, when you get outside of Philadelphia and Pittsburgh and Erie and Harrisburg—a couple of major urban areas—we are a very rural State. We have literally millions of people who live in the demographic category that we refer to as rural areas. Those children—one-third of them—rely upon either the Children's Health Insurance Program or the Medicaid Program. So it helps a high percentage of rural children.

In the midst of this economy, when those rural communities in Pennsylvania and across the country have been disproportionately adversely impacted by high energy costs, including everything from gasoline to home heating oil, to all kinds of other energy costs, when they have also been hit hard by the downturn in the economy—job losses are rampant in rural communities—when you factor in those realities with the dependence or reliance they have on this program, it is critically important we provide as much in the way of resources as we can and outreach to get those children enrolled in rural areas, as well as in our urban and even suburban communities.

I want to conclude with a recitation of some myths and facts, some of which we have heard on the floor in the debate over the last couple days. I will do just one, two, three, four—about four or five myths.

Myth No. 1, the children's health insurance bill reduces documentation requirements, allowing illegal immigrants to receive benefits. That is the myth.

Here are the facts.

Fact No. 1: Under current law, only individuals applying for Medicaid are subject to the citizenship documentation requirements. This bill actually extends those requirements to the Children's Health Insurance Program, requiring documentation in CHIP just like documentation is required in the Medicaid Program. You would never know that by some of the debate here.

Fact No. 2 about this documentation issue: Because the requirements have resulted in the widespread denial of coverage to many citizens, the children's health insurance bill also gives States a new way to prove citizenship through matching Social Security Administration records. So that is further help on documentation.

Fact No. 3 under this section: These citizen documentation provisions are the same as they were in the children's health insurance bill passed in the Senate overwhelmingly—overwhelming—with bipartisan support in 2007. So it is the same. So for those who are creating the myth that somehow it is new, that is not true.

Myth No. 2: The bill ends the mandatory 5-year waiting period for legal immigrants to receive benefits—opening the program to abuse by illegal immigrants. It is another myth.

Fact No. 1 under this myth: The bill allows but does not require—it allows but does not require—States to cover legal immigrant children without forcing them to wait 5 years for coverage. Why should a child who is a legal immigrant or why should a pregnant woman in the same circumstance—why should they have to wait 5 years? Does that make any sense at all? Does that make any of us safer or does that make our country better to have vulnerable people wait to get these benefits, especially when 23 States are doing this now? By listening to the debate, you would think this is some new concept that just fell out of the sky. Twenty-three States right now are doing this. So what does this bill do? It allows States to cover legal immigrant children without forcing them to wait 5 years for coverage.

Only immigrant children here legally—legally—are eligible for the benefits provided by Medicaid and the Children's Health Insurance Program. So if anyone uses the word ''illegal'' in this context, you know automatically they are deliberately attempting to mislead people.

Children and pregnant women who will now be eligible must document their immigration status. State Medicaid agencies use the Bureau of Citizenship and Immigration Services' automated SAVE system to verify the immigration status of legal immigrants applying for Medicaid. So that is a protection that is built into this bill.

The next myth: This bill will allow children from families making over $80,000 per year to receive coverage while poor children are still not enrolled.

That is another myth. This bill would extend coverage to 4 million more low-income children and help struggling families in this time of economic downturn. The CHIP bill prioritizes enrolling low-income children by establishing a performance-based system to reward States for enrolling low-income kids while giving them new tools to do so. So we incentivize States to go out and enroll more children, which is a worthy thing to do, and critically important.

Under the bill, States would be allowed to designate CHIP funds to help families afford private coverage afforded by employers or other sources.

Finally, under this section, the bill maintains provisions to reduce the Federal match rate for the cost of covering children above 300 percent of the Federal poverty level.

Let me get to two more myths, and I will conclude.

The next myth: The revenue stream to pay for the Children's Health Insurance Program with tobacco tax is unsteady and will not be able to fund the program in the future, increasing the burden on taxpayers.

That is the myth. We have heard that a lot. The fact is, according to the nonpartisan Congressional Budget Office, the proposed $31.5 billion in spending will be fully paid for by the fee increase to tobacco products over the authorized 5-year timeframe.

Finally, this myth: Democrats have made unilateral changes to CHIP, which has jeopardized the bipartisan support of the previous version passed by the Senate.

Fact: The CHIP legislation introduced this year is almost identical to the legislation in 2007 which received broad bipartisan support in the House and the Senate. Two prior bipartisan efforts were blocked by President Bush when he vetoed the legislation.

Providing health care for children is not a Democratic or Republican issue. We know that. It is a moral issue and one that all Senators should support. The few unresolved policy disagreements were put to a vote in the committee. So we have had a committee vote as well.

So I would conclude tonight with where I began. What is the Senate going to do when faced with the question, the stark and fundamental question: Are we going to act this week to cover 4.1 million more children? It is up or down.

There have been a lot of discussions about so-called immigration issues which I think have been misleading. A lot of the debate is about numbers. But we are either going to act to do this, to cover 4 million kids, or not.

Finally, what will the Senate do this week to speak to that one mother and to say to her: We understand a little bit—a little bit—about what you are going through, and we understand that with all of the love you surround your son or daughter with, we know you cannot provide them health insurance on your own. We are going to help you because we have the program that has been in place for 15 years, which is one of the best pieces of legislation this body or the other body ever voted on; we know how to help you, and we are going to do everything we can to help you. We know this economy is especially tough on that mother and that family. We are going to act to help you through this difficult period in your life so that you can have the peace of mind to know that your son or daughter at least—at least—is covered by health insurance and can get six visits to the doctor in a year. That is not asking too much of all of us and of the American people, to show some degree of understanding and some degree of solidarity with that mother and her children.

Thank you, Mr. President. I yield the floor and note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DURBIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

Mr. DURBIN. Mr. President, I ask unanimous consent to speak as in morning business.

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

ERIC HOLDER NOMINATION

Mr. DURBIN. Mr. President, I rise in support of the nomination of Eric Holder to be Attorney General of the United States. As a member of the Judiciary Committee, I have given especially close consideration to this nomination. I met privately with Eric Holder, reviewed his record, listened to his sworn testimony, and I have come to the conclusion that he will be an outstanding Attorney General.

On January 15 and 16, the Judiciary Committee held a hearing on Mr. Holder's nomination where he was asked many questions from the committee members on both sides of the aisle. He stayed until every member of the committee had asked every question they wished. Then, following the hearing, Mr. Holder responded to literally hundreds of written followup questions from members of the committee.

Last week, the Judiciary Committee was scheduled to vote on his nomination. Despite a lengthy 2-day hearing which included multiple outside witnesses and Mr. Holder's timely response to the questions, the Republicans asked to postpone the committee's vote on Mr. Holder's nomination. That is their right under the Senate rules, but it is disappointing that despite Mr. Holder's full cooperation, we have been unable to move forward on this nomination to this point. As a result, the crucial position of Attorney General remains unfilled and the Obama administration's national security team is incomplete.

Due to the delay, the committee will now vote on Mr. Holder's nomination as early as tomorrow. I urge my colleagues on both sides of the aisle to support the nomination so we can have new leadership in place at the Justice Department.

I believe Eric Holder has the experience, independence, and commitment to the rule of law to reform the Justice Department. He will be one of the most qualified Attorneys General, having previously served as Deputy Attorney General, U.S. attorney, judge, and a career Justice Department attorney. Mr. Holder will need to bring all of that experience to bear to restore the integrity of the Department which has descended to a sad state today.

However, it is more than just experience that he will bring. The Attorney General is the people's lawyer, not the President's lawyer, so he or she needs to have the backbone on occasion, if necessary, to stand up for what is right, even if it means disagreeing with the President.

I have had many differences of opinion with John Ashcroft, our former Attorney General under the previous President, but there was a moment in history when he was literally in an intensive care unit and asserted his authority as Attorney General to say no to the President. It took courage. It took commitment. It took professionalism. We should expect nothing less of those who serve in that capacity.

There can be little doubt about Eric Holder's willingness to say no to the President. He has demonstrated a lot of independence throughout his career. As Deputy Attorney General, he recommended expanding the Starr investigation into the Monica Lewinsky affair, and he recommended the appointment of a special prosecutor to investigate a member of President Clinton's Cabinet. He has been involved in the investigation and prosecution of Members of Congress in both political parties.

The testimony of former FBI Director Louie Freeh, in support of Mr. Holder, is a good indication of his independence. No one would accuse Mr. Freeh of being a partisan Democrat. He was a strong supporter of former New York mayor Rudy Giuliani and also of JOHN MCCAIN's efforts when he ran for President. He has been a vocal critic of former President Clinton. Mr. Freeh included his decisions to pardon Marc Rich and offer commutation to the FALN as things he disagreed with. But Mr. Freeh enthusiastically supports Mr. Holder's nomination. Here is what he said:

> The Attorney General is not the President's lawyer. . . . the President has a White House counsel for those purposes. And I know that Eric Holder understands the difference. I think he would be very quickly able to say no to the President if he disagreed with him. And I think that's the confidence and trust we need in that position.

Mr. Holder is also supported by dozens of other prominent Republican lawyers, such as former Attorney General William Barr and former Deputy Attorney General Jim Comey, a man who, incidentally, distinguished himself during the previous administration in his service at the Justice Department.

President Obama respects Eric Holder's independence. At his hearing, Mr. Holder testified about a conversation he had with the President after he accepted the offer. The President said:

> Eric, you've got to understand you have to be different. You know, we have a pretty good relationship. That's probably going to change as a result of you taking this position. I don't want you to do anything that you don't feel comfortable doing.

What a refreshing exchange. It gives me hope that the Attorney General, if it is Eric Holder, in this Justice Department will chart a new and important course for this Nation.

In addition to Mr. Holder's experience and independence, there is little

doubt about his commitment to the rule of law. I voted against the two previous Attorneys General because of their involvement in one issue: torture.

As White House Counsel, Alberto Gonzales was an architect in the Bush administration's policy on interrogation, a policy which has come into criticism not only in the United States but around the world. His successor, Michael Mukasey, refused to repudiate torture techniques such as waterboarding. That was unfortunate because Mr. Mukasey really brought a stellar resume to the job, but that really was a bone in my throat that I couldn't get beyond, and I voted against his nomination.

Now, during his confirmation hearing, Eric Holder gave a much different response. When asked directly, he said: ''Waterboarding is torture.''

Those three words resonated throughout the committee room and across the Nation among many Americans who had been concerned about this important issue and literally gave a message to the world that there was a new day dawning in Washington.

I also asked Mr. Holder the same question I asked Attorneys General Gonzalez and Mukasey: Does he agree with the Judge Advocates General, the four highest ranking military lawyers, that the following interrogation techniques violate the Geneva Conventions: painful stress position, threatening detainees with dogs, forced nudity, or mock execution. Mr. Holder said:

> The Judge Advocate General Corps are in fact correct that those techniques violate Common Article 3 of the Geneva Conventions.

Some of my colleagues on the other side of the aisle have suggested that Eric Holder's opposition to torture will somehow lead to a witch hunt against former Bush officials. Frankly, this seems like a weak excuse to delay the confirmation of a well-qualified nominee.

Here are the facts: President Obama and Eric Holder made it clear that while no one is above the law, the administration is going to move forward, not back. The goal to investigate the Bush administration does not come from the Obama administration but from others such as retired major general Antonio Taguba, who led the U.S. Army's official investigation into the Abu Ghraib prison scandal.

Here is what General Taguba recently said:

> The Commander in Chief and those under him authorized a systematic regime of torture. . . . there is no longer any doubt as to whether the [Bush] administration has committed war crimes.

In the words of General Taguba:

> The only question that remains to be answered is whether those who ordered the use of torture will be held to account.

Indeed, the facts are troubling. Former President Bush and former Vice President Cheney have acknowledged authorizing the use of waterboarding which the United States had previously prosecuted as a war crime. Susan Crawford, the Bush administration official who ran the Guantanamo military commissions, said that the so-called 20th 9/11 hijacker cannot be prosecuted because ''his treatment met the legal definition of torture.''

Now it appears some Republicans are holding up Eric Holder's nomination because of the problems of the previous administration. A headline in the Washington Post this last Sunday highlighted the irony. It said: ''Bush Doctrine Stalls Holder Confirmation.'' Apparently, some Republicans are opposing Eric Holder because of their concern that former Bush administration officials may be prosecuted for committing war crimes.

Here is what the junior Senator from Texas said:

> I want some assurances that we're not going to be engaging in witch hunts.

But Mr. Holder has made it clear in his testimony there will be no witch hunts. He testified:

> We will follow the evidence, the facts, the law, and let that take us where it should. But I think President-elect Obama has said it well. We don't want to criminalize policy differences that might exist between the outgoing administration and the administration that is about to take over.

The junior Senator from Texas also expressed concerns about Eric Holder's ''intentions . . . with regard to intelligence personnel who were operating in good faith based upon their understanding of what the law was.'' But Mr. Holder has made his intentions clear. He testified:

> It is, and should be, exceedingly difficult to prosecute those who carry out policies in a reasonable and good faith belief that they are lawful based on assurances from the Department of Justice itself.

What more would you expect a man aspiring to be Attorney General to say? It certainly would be inappropriate to seek an advance commitment from any nominee for Attorney General that they will definitely not investigate allegations of potential criminal activity. No responsible Attorney General would ever say that, nor should that person be confirmed if they made that statement.

Senator LINDSEY GRAHAM, another Republican member of the Judiciary Committee, recognizes that fact. Senator GRAHAM, also a military lawyer still serving, said:

> Making a commitment that we'll never prosecute someone is probably not the right way to proceed.

He went on to say:

> I don't expect [Holder] to rule it in or rule it out. In individual cases if there's allegations of mistreatment, judges can handle that and you can determine what course to take.

I think Senator LINDSEY GRAHAM has hit the nail on the head. I hope no one will use this false specter of a witch hunt as an excuse to oppose a fine nominee.

I say to my colleagues, if you have an objection to Eric Holder based on his qualifications, vote against him. But don't oppose him because the previous administration may have been guilty of wrongdoing which may lead to a prosecution. There are too many hypotheticals in that position. In fact, these misdeeds are the reasons we need Eric Holder's leadership.

Here is what President Obama has said about the need to reform the Justice Department:

> It's time that we had a Department of Justice that upholds the rule of law and American values, instead of finding ways to enable a President to subvert them. No more political parsing or legal loopholes.

I think Eric Holder is the right person to fill the vision of President Obama. After 8 years of a Justice Department that too many times put politics before principle, we now have a chance to confirm a nominee with strong bipartisan support who can restore the Department to its rightful role as guardian of our fundamental rights.

I urge my colleagues to support Eric Holder's nomination.

AMENDMENT NO. 39

Mr. DURBIN. Mr. President, I ask unanimous consent that the pending Baucus amendment No. 39 be agreed to, the motion to reconsider be laid upon the table, and the bill, as thus amended, be considered as original text for the purpose of further amendment.

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

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate resumes consideration of H.R. 2 on Wednesday, the time until 11 a.m. be for debate with respect to McConnell, et al., amendment No. 40, with the time equally divided and controlled between the majority and Republican leaders or their designees; that no amendments be in order to the amendment prior to a vote in relation to the amendment; that at 11 a.m. the Senate proceed to vote in relation to the McConnell amendment, No. 40; provided further, if the McConnell amendment is agreed to, the bill, as thus amended, be considered as original text for the purpose of further amendments.

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

MORNING BUSINESS

Mr. DURBIN. I ask unanimous consent the Senate proceed to a period of morning business, with Senators permitted to speak for up to 10 minutes each.

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

FURTHER CHANGES TO S. CON. RES. 70

Mr. CONRAD. Mr. President, section 227 of S. Con. Res. 70, the 2009 Budget resolution, permits the chairman of the Senate Budget Committee to revise the allocations, aggregates, and other appropriate levels in the resolution for

legislation making improvements in health care, including, under subsection (a), legislation that reauthorizes the State Children's Health Insurance Program, SCHIP. The revisions are contingent on certain conditions being met, including that such legislation not worsen the deficit over the period of the total of fiscal years 2008 through 2013 or the period of the total of fiscal years 2008 through 2018. In addition, section 227 limits the amount of the adjustment in outlays to no more than $50 billion over the period of the total of fiscal years 2008 through 2013.

I find that Senate amendment No. 39, an amendment in the nature of a substitute to H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009, satisfies the conditions of the reserve fund to improve America's health. Therefore, pursuant to section 227, I am adjusting the aggregates in the 2009 budget resolution, as well as the allocation provided to the Senate Finance Committee.

I ask unanimous consent that the following revisions to S. Con. Res. 70 be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2009—S. CON. RES. 70; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 227 DEFICIT-NEUTRAL RESERVE FUND TO IMPROVE AMERICA'S HEALTH

[In billions of dollars]

Section 101	
(1)(A) Federal Revenues:	
FY 2008	1,875.401
FY 2009	2,033.468
FY 2010	2,212.116
FY 2011	2,420.408
FY 2012	2,513.164
FY 2013	2,633.975
(1)(B) Change in Federal Revenues:	
FY 2008	−3.999
FY 2009	−63.931
FY 2010	28.718
FY 2011	−7.662
FY 2012	−144.431
FY 2013	−116.244
(2) New Budget Authority:	
FY 2008	2,564.237
FY 2009	2,548.889
FY 2010	2,574.071
FY 2011	2,701.088
FY 2012	2,744.638
FY 2013	2,871.918
(3) Budget Outlays:	
FY 2008	2,466.678
FY 2009	2,575.667
FY 2010	2,630.249
FY 2011	2,718.860
FY 2012	2,728.215
FY 2013	2,861.791

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2009—S. CON. RES. 70; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 227 DEFICIT-NEUTRAL RESERVE FUND TO IMPROVE AMERICA'S HEALTH

[In millions of dollars]

Current Allocation to Senate Finance Committee	
FY 2008 Budget Authority	1,102,801
FY 2008 Outlays	1,104,781
FY 2009 Budget Authority	1,092,354
FY 2009 Outlays	1,093,724
FY 2009–2013 Budget Authority	6,161,994
FY 2009–2013 Outlays	6,170,488
Adjustments	
FY 2008 Budget Authority	0
FY 2008 Outlays	0
FY 2009 Budget Authority	10,621
FY 2009 Outlays	2,387
FY 2009–2013 Budget Authority	50,062
FY 2009–2013 Outlays	32,819
Revised Allocation to Senate Finance Committee	
FY 2008 Budget Authority	1,102,801
FY 2008 Outlays	1,104,781
FY 2009 Budget Authority	1,102,975
FY 2009 Outlays	1,096,111
FY 2009–2013 Budget Authority	6,212,056
FY 2009–2013 Outlays	6,203,307

GEITHNER NOMINATION

Mr. KOHL. Mr. President, yesterday the Senate confirmed Timothy Geithner as the Secretary of Treasury with my support. Mr. Geithner has the experience and the knowledge to lead the country through these economic hard times.

The Treasury Department is facing an uphill battle to provide appropriate monetary policy and regulations to get our economy back on track. Congress has been working with Federal Reserve and the Treasury Department to find ways to jump-start our economy. Congress recently approved the release of the second half of the TARP funds and is working with the new administration to create an effective economic stimulus package. I am pleased that President Obama and Mr. Geithner have committed themselves to restructuring the TARP but stress the importance of reforms which increase accountability, transparency, and help homeowners. Furthermore, the Treasury Secretary must implement meaningful and effective policies to avoid another system-wide failure and promote long-term economic stability. Mr. Geithner's career in the Treasury Department and the Federal Reserve Bank of New York has made him well qualified for the difficult task at hand.

Mr. SPECTER. Mr. President, I have sought recognition to discuss my vote against the nomination of Mr. Timothy F. Geithner to be Secretary of the Treasury.

I was originally inclined to support the nomination to enable President Obama to get his team together and begin addressing the economic crisis. As I have said publicly, I want to be supportive of President Obama and I understand the importance of assembling his full economic team to address the critical problems facing our Nation's economy. After considerable thought, I have decided I cannot support this nomination. I have since taken a close look at the circumstances of Mr. Geithner's failure to pay Social Security and Medicare payroll taxes from 2001 to 2004 while an employee at the International Monetary Fund—IMF. Then, I spoke to Finance Committee ranking member CHUCK GRASSLEY who provided some additional insight. Based on those factors, I decided to vote against Mr. Geithner.

International organizations such as the IMF are exempt from the employer contribution of payroll taxes, so U.S. citizens who work there are required to pay their portion as if they are self-employed. During an IRS audit conducted in 2006, it was discovered that Mr. Geithner failed to pay these taxes and he then paid what was owed for tax years 2003 and 2004. Despite having made the same error in previous years, he did not pay for 2001 and 2002 because the statute of limitations had expired. Only after the non-payment was discovered during the vetting process by the Obama transition team in late-2008 did Mr. Geithner finally pay for tax years 2001 and 2002.

Mr. Geithner was paid an extra sum, or tax allowance, by the IMF with the expectation that he would use it to pay the IRS for his payroll tax liabilities. According to remarks by Senator GRASSLEY at Mr. Geithner's confirmation hearing, ''Furthermore, the nominee received a tax allowance from the IMF to pay the difference between the 'self-employed' and 'employed' obligations of his Social Security tax.'' At his confirmation hearing, Mr. Geithner acknowledged receiving various documents detailing his obligations as an American employee at the IMF. The IMF provides its employees with a tax manual at the time they are hired that includes information describing how to pay self-employment taxes. Page 2 of the document states, ''U.S. citizens who are staff members are required to pay U.S. tax are entitled to receive tax allowances.'' Page 12 of the document states, ''Employees of international organizations are considered self-employed for purposes of social security taxes. As such, they must pay both the employer's and the employee's share of social security taxes. The Fund gives you a tax allowance for the employer's share of social security taxes only. You are responsible for the employee's portion of this tax.'' Mr. Geithner signed a document each year in order to receive this extra tax allowance. At the end of the tax allowance form are the words, ''I hereby certify that all the information contained herein is true to the best of my knowledge and belief and that I will pay the taxes for which I have received tax allowance payments

from the Fund.'' Also, the IMF provides its employees with detailed statements of their liabilities.

These errors set a bad example for other taxpayers when the Government seeks to collect back taxes. We can be assured that the precedent set by Mr. Geithner's neglect will be cited repeatedly by future offenders. Mr. Geithner's conduct would be problemsome on the confirmation of any high-level officers, but especially so for Secretary of the Treasury. The Secretary has within his jurisdiction the Internal Revenue Service which is responsible for collecting taxes. With the full Senate confirming Mr. Geithner, it is a virtual certainty that other taxpayers will cite his situation as a reason or excuse for their not having paid taxes. If the issue of failure to pay taxes goes to court in either civil or criminal proceedings, it will be an obvious defense or argument by defense counsel in mitigation or defense.

President Obama has placed ethics reform as a top priority for his administration. In his inaugural address, he said, ''Those of us who manage the public's dollars will be held to account, to spend wisely, reform bad habits, and do our business in the light of day, because only then can we restore the vital trust between a people and their government.'' That is the appropriate tone to set an example, especially for young people, where in the past election there has been a resurgence of interest in voting and government. We ought to do everything we can to maintain that interest and momentum.

ECONOMIC STIMULUS

Mr. SPECTER. Mr. President, I also wish to discuss the precarious state of our United States economy, which is facing one of the most dire economic crises in history. As a member of the Senate Appropriations Committee, I understand that it is imperative that the Federal Government use all means at its disposal to address these problems.

It is critical as we move forward that the Appropriations Committee and the Senate focus on spending our Nation's dollars on worthwhile projects, which both benefit the American people on their merits and will also lead to an increase in jobs.

To this end, I wish to highlight a few projects in my home State of Pennsylvania which appear to have significant potential to stimulate economic investment, as well as return our unemployed workers to the workforce.

The fastest way to put people to work on transportation infrastructure projects is to finance highway repairs. These repairs support construction jobs that can start immediately. Additionally, infrastructure repairs ensure an acceptable level of safety and reliability on existing highway networks, which is critical in a State like Pennsylvania that has 6,000 structurally-deficient bridges.

According to the Pennsylvania Department of Transportation, Pennsylvania could obligate $1.5 billion on 313 shovel-ready highway repair projects. These projects all focus on Pennsylvania's bridge deficiencies, pavement needs and safety concerns, as well as create jobs and achieve meaningful infrastructure improvements. Additionally, all of the highway infrastructure repairs can be put out to bid within 6 months, with construction starting shortly thereafter.

The Pennsylvania Department of Transportation has also provided me with a list of 147 public transportation projects totaling $700 million that, according to transit agencies around the State, are ready to begin. The projects include replacing catenary pole involved in electrified train service, station improvements, alternative fuel bus purchases and intermodal centers.

The Port of Pittsburgh Commission in Pennsylvania has identified over $580 million in shovel-ready project work that could be started in 6 months, of which $430 million could be completed in 2 years and the remaining $150 million could be completed in 3 years.

The largest share of that money would be applied to the Lower Monongahela Improvement Project for Locks and Dams 2–3–4, a project 5 years behind the original completion date of 2004. Without investment from the economic stimulus, the project will not otherwise be completed until the 2019–2022 period. Stimulus funding could result in a working, reliable chamber, a major improvement over the current schedule. Funding can also be provided for emergency repairs to Emsworth Dam.

These projects would add or preserve tens of thousands of high-skilled, high-paying jobs for the southwest Pennsylvania region, including permanent employees at facilities that depend on river transportation, such as U.S. Steel's Clairton Coke Works, ArcelorMital's Coke Works, Eastman Materials, Welland Chemical, Kinder Morgan, Ashland Petroleum, Consol Energy and the Elrama Power Plant.

Previous delays have resulted in increasing costs, interruptions to service and benefits foregone. The U.S. Army Corps of Engineers calculates that the region has already lost over $1.2 billion in benefits that can never be recuperated.

Health care is one of the largest drivers of our economy and a worthwhile investment in the physical and economic health of the country.

In 2002, the Northeastern Pennsylvania Medical Education Development Consortium was formed to explore the feasibility of locating a new medical college in northeastern Pennsylvania. A 2006 feasibility study made the need for a medical school clear. This region of Pennsylvania has shortages of physicians in many specialties and over one-third of the practicing physicians are expected to retire in the next decade.

To address this critical need, the Commonwealth Medical College is scheduled to open in 2009 and has already received investments of $35 million from the Pennsylvania Redevelopment Assistance Capital Program and $25 million from Blue Cross of Northeastern Pennsylvania, as well as State, Federal, and private philanthropic sources.

Additional funding will be used to support construction of the college, which will attract medical and biomedical research to northeastern Pennsylvania, improving the local and regional economy, as well as the health of the population. Over the next 20 years, the Commonwealth Medical College is expected to greatly increase the number of physicians in the area, add $70 million to the local economy and create 1,000 jobs.

This project also has national implications, as the research conducted there will focus on healthcare conditions affecting the aging population, including research on cardiovascular disease and diabetes.

There are numerous higher education projects throughout the Commonwealth of Pennsylvania which exemplify the types of activities that this country should target as it searches for an effective means to stimulate the economy. These meritorious projects provide necessary infrastructure improvements to many colleges and universities in my home State, while at the same time creating a myriad of new jobs and stimulating the economy. It is my understanding that all of these projects are ready for construction within 6 months or sooner.

Specifically, the Pennsylvania State System of Higher Education, which represents 14 public universities in my home State, provided me with a list of 47 projects totaling $445 million. These programs focus on new building construction, renovations to existing buildings and energy conservation measures. The Pennsylvania Commission for Community Colleges, which represents the 14 community colleges throughout Pennsylvania, also provided me with a list of 34 projects totaling $128 million. Selected projects include building renovation and construction, public safety programs, infrastructure repairs and upgrades, and new resources for education and training.

In regard to the private colleges and universities in Pennsylvania, the Association of Independent Colleges and Universities of Pennsylvania, which represents 86 private institutions, provided me with a list of 42 projects totaling $385 million. Many of these projects focus on the construction of new academic buildings, the renovation and expansion of training facilities and improvements to existing infrastructure.

In many cities and small towns in Pennsylvania aging sewer pipes and treatment plants are malfunctioning, leading to sewage contamination of local freshwater. In many areas across Pennsylvania, and the country, water

infrastructure is 50, 60 years old or much older.

Throughout Pennsylvania the need for funding is great, because without it many of my constituents, a significant number of whom are retired and on a fixed income, are facing sewer rate increases of up to 100 percent. An investment in water infrastructure is a wise one, as it will lead to construction jobs in areas where jobs are often hard to come by, while relieving a significant financial burden on residents.

In western Pennsylvania, the Allegheny County Sanitary Authority, which services communities in and around Pittsburgh, is assisting municipalities in that region seeking to meet clean water compliance standards. Currently, the Pittsburgh region is facing its largest and most costly public works project thus far, the rehabilitation and long-term maintenance of 4,000 miles of sewers that serve nearly one million residents in the area. Additionally, in central Pennsylvania, the Borough of Philipsburg's outdated storm and wastewater collection system overflows during periods of heavy rain. The cost of modernizing this sewer system is significant, but it is necessary.

While these are just two examples of water and sewer projects in Pennsylvania, an investment in wastewater infrastructure would create construction jobs, and ease the financial burden on the residents in many economically disadvantaged regions of Pennsylvania.

The Environmental Protection Agency's Brownfields Remediation Grant Program provides funding for private developers to take real property business sites with environmental concerns and clean them up in order to redevelop. Redeveloping this land creates space for new businesses—with new jobs—to expand in areas that might not otherwise be available. Pennsylvania alone has an estimated 150,000 acres of brownfields with great potential for re-use.

Brownfields cleanups create jobs not only through the workers needed to do the cleanups themselves, but subsequently with the new businesses that occupy the property. I recently met with a developer in Pennsylvania who is prepared to immediately undertake cleanup projects totaling $283 million in my home State. Combined, his projects could create an estimated 322,225 new jobs in Pennsylvania.

For every $1 invested into brownfields cleanups, an estimated $15–20 are immediately returned to the economy in the form of job creation and State and Federal tax revenue. Jobs created by brownfields cleanups—both before and after—are taken by locally available workers, stimulating local economies. This is exactly the result we should be requiring from every program in the stimulus package.

These projects include cleanups in Bensalem, King of Prussia, Lehman Township, Bridgeport, Frazer, Norristown, Malvern, Limerick, Conshohocken, West Norriton, and Bala Cynwyd, Pennsylvania. These are all areas in Pennsylvania that could certainly use targeted economic development. I understand that there is a question over how fast this money can be spent, and I agree that money from the stimulus be put to use as soon as possible after passage of the bill. However, the developers with whom I have spoken have all assured me that brownfields funding can be used within the 120 day benchmark to determine shovel-ready projects. Programs, such as this one, should be the focus of the stimulus.

I recently met with a group of Pennsylvania State Senators and Representatives who expressed their concern over cleanup efforts in the Chesapeake Bay Watershed, a large watershed which covers much of Pennsylvania, Maryland, and Virginia. Cleanup efforts from agricultural runoff and other environmental impacts can be expensive. The Watershed Rehabilitation Program can mediate some of the enormous costs to individual landowners—often small business farmers—who are tasked with the cleanup of their own property.

These cleanup efforts will require labor—stimulating the workforce while simultaneously making our environment a cleaner place for our children and grandchildren.

Military construction projects funded through the stimulus must be identified as priorities by military leadership and be at or near design completion so that construction can be started in short order. These projects must help modernize our military support structure and defense capabilities. The following projects are both shovel-ready and of vital importance to the State, the military and the Nation.

The End Item Shipping and Receiving Facility at Letterkenny Army Depot is a perfect example of a shovel ready project that will create construction work for Pennsylvanians and will enhance Letterkenny's capability to support the movement of military equipment. The identified site is on Federal land, close to utilities, next to rail and ground transportation and in the depot industrial area. Design is complete and Congress authorized $7.5 million for the facility in the John Warner National Defense Authorization Act for 2007—P.L. 109–365. Regrettably, this valuable project failed to move forward and additional funding is needed to complete the project at this time.

Another vital military construction project is the Hermitage Readiness Center, in Hermitage, PA. When complete, the facility will support 128 Pennsylvania Army National Guard members who are currently housed in substandard and undersized buildings. This project is a high priority for the Pennsylvania Adjutant General, as land has been acquired and the design is 99 percent complete. I am told that construction could be started within 3 months, creating construction jobs almost immediately.

A third military construction project is the Combined Surface Maintenance Shop at the Fort Indiantown Gap Vehicle Paint Prep Facility in Annville, PA. This facility will reduce hazardous waste associated with paint operations, create safer working conditions, increase productivity and reduce costs. I understand that land and environmental reviews are complete and the design is 75-percent complete, allowing for construction within 3 or 4 months, were funds to be made available.

Vital funding in the economic stimulus bill will allow us to improve the care we provide to our veterans. According to the Pennsylvania Department of Military and Veterans Affairs, necessary improvements to the Southeastern Veterans' Center in Spring City, PA, could commence with $17 million in Federal funding. A new long term health care facility would replace the ten substandard modular units currently on the premises of the Southeastern Veterans' Center. This proposed project will include the construction, furnishing and equipping of a multi-story facility with the capacity to provide skilled nursing care and dementia care for 120 residents. Further, this project will provide appropriate housing for the veterans and will enable the Southeastern Veterans' Center to entirely vacate the substandard modular units, while reducing costly maintenance.

In addition to major construction projects, I understand that Pennsylvania has nearly $119 million in non-recurring maintenance and minor construction projects that are needed and could be completed in Fiscal Year 2009 were funds made available at this time. The importance of these smaller projects should not be ignored, as many of them hold the potential to impact positively the lives of our veterans in short order.

Providing funds in the economic stimulus package for construction and maintenance projects at national parks could have a stimulating affect on the economy and put people to work. Among the projects in Pennsylvania that could benefit from economic stimulus funding is the Flight 93 National Memorial, which will honor the 40 passengers and crewmembers of United Airlines Flight 93 who gave their lives to save countless others on September 11, 2001. I have worked with members of the Pennsylvania delegation to secure funding for this most important project in the annual appropriations bills. However, it is my understanding that an additional $6.2 million is required for the first phase of construction to commence.

Additionally, according to the Congressional Research Service, recent estimates suggest that the National Park Service has a deferred maintenance backlog of almost $10 billion. Deferred maintenance projects often include important construction work on buildings, trails, recreation sites and other

infrastructure within the parks. For example, according to Gettysburg National Military Park officials, the current maintenance backlog at the park would cost $55 million to complete. In addition, there are deferred maintenance projects at Valley Forge National Historical Park, Independence National Historical Park and the Delaware Water Gap National Recreation Area Park, among others.

Funding these projects will not only put people to work, but will go a long way to support the ongoing efforts to preserve, protect and enhance our country's most precious and historically significant national treasures.

In conclusion, while I would like to hear further from the administration and other economic experts to give us guidance on addressing the current economic crisis, the projects which I have outlined in Pennsylvania are the kind of expenditures that will provide the most realistic opportunity to stimulate the economy.

TRIBUTE TO SENATORS

KEN SALAZAR

Mr. HATCH. Mr. President, I stand before the Senate today to voice my great respect and hope in the Senator from Colorado, the Honorable Ken Salazar, who has recently left this Chamber in order to serve as Secretary of the Interior under the Obama administration. It is with sorrow that I say goodbye to my good friend who has served with honor and dedication since 2005. Although Ken only served for a few years in the Senate, he has left his mark on us all and will be remembered for his dedication and service not only to his country but to Utah's neighbor the great State of Colorado.

Ken Salazar's personal history is a testament to his character and accomplishments. His family first settled in America just over 400 years ago, 12 generations back. Ken's parents knew the value of teaching their eight children about hard work and dedication, and from them he learned the worth of industry on his family's ranch growing up. Those early years on the ranch taught Ken about the importance of hard work, integrity, and dedication. It is also from these early experiences that Ken grew to love the beauty of the natural resources our Nation has to offer.

I am confident that the years of experience Mr. Salazar has worked on environmental policy in the West will serve him well in his new position as Secretary of the Interior. He has a deep-rooted passion for clean, renewable, and affordable energy as well as protecting our country's precious natural resources. I believe he will take quite naturally to his new role as our Nation's top public lands manager, and we will be well served by his sensitivity to those natural treasures we value the most.

In short, Ken Salazar has the experience and the passion required for the role he has taken on as Secretary. I thank him for his excellent service in the Senate and look forward to seeing good things from him in the coming years.

AFRICA

Mr. FEINGOLD. Mr. President, in recent years more and more observers have noted Africa's failing states, ungoverned spaces and pirate-infested waters, and the threat they pose to our own national security. I have long raised these concerns on this Senate floor and I am pleased that they are receiving increasing attention. However, it is not enough to simply acknowledge Africa's security challenges; nor is it sufficient to shift resources toward them, although that is a good start. We must institute long-term strategies to further our national security goals while developing sustainable partnerships with Africans that advance our mutual interests and support nascent democratic institutions.

As a 16-year member and the current chairman of the Subcommittee on African Affairs, I have closely followed U.S. policy toward the continent for many years. Too often, I have found that our approach has been driven by short-sighted tactics designed to buy influence or react to crises. In the absence of comprehensive interagency strategies, these tactics often undermine long-term efforts to build civilian institutions and strengthen the rule of law. This must change if we are to successfully pursue our strategic objectives on the African continent. It remains critical—and long overdue—that the United States develop a carefully planned and long-term approach to both promoting stability and combating terrorism in Africa. I would like to offer some thoughts today on key components of such an approach.

During our December recess, I traveled to the headquarters of the new Africa Command in Stuttgart, Germany and discussed a range of issues with senior officials there. Although I have been focused on AFRICOM since its inception—and on the idea of such a command prior to that—I was reminded during my trip of the very important and strategic roles that AFRICOM, if advanced properly, can play. These roles include helping to develop effective, well-disciplined militaries that adhere to civilian rule, strengthening regional peacekeeping missions, and supporting postconflict demobilization and disarmament processes. If carried out properly, AFRICOM's work can complement that of the State Department, USAID, and other U.S. Government agencies working on the continent and help contribute to lasting peace and stability across Africa.

It is because of the significant need for this important work that we must support AFRICOM, while also working to ensure that it adheres to its defined military mandate and defers to the State Department as the lead on policy matters. The challenge for AFRICOM is to strike the right balance with our civilian agencies and not become our primary representation throughout Africa. Serious work remains to be done in ensuring that the Command is operating within comprehensive interagency national security strategies and squarely under the authority of our Chiefs of Mission. I also remain concerned that AFRICOM has been unable to adequately convey its role within a larger policy framework to Congress, to the American people or to African governments and regional organizations—perhaps its most important partners.

It is true that the Command's initial rollout was fraught with mistakes and the Command understandably received a cool reception on the continent, among civilian agencies and here in Congress. But I am confident from my recent meetings that the staff in Stuttgart has recognized and is learning from these setbacks. Rather than merely criticizing, we in Congress should work across the spectrum of agencies here in Washington as well as with AFRICOM's leadership to help craft a combatant command that is doing the right job, for the right reasons and can thus be adequately resourced. In the months ahead, I intend to use my role as chairman of the Subcommittee on African Affairs to do just that.

I hope, however, that no one thinks for a minute that military tools alone are sufficient to transform the underlying causes of violence and instability in Africa. To promote long-term stability, it is crucial that we strike a better balance between our military relationships and our support for civilian institutions and the rule of law.

Achieving that balance is no small task and it will only be possible if we invest seriously in new institutional capacities for our civilian agencies on the continent. This begins with ensuring our embassies have the Foreign Service officers and resources they need to do the job properly. We cannot continue to shortchange our embassies across Africa while we focus on one or two other locations around the world. We need to make sure our embassies have sufficient resources to meet the challenges of today, and to identify the challenges of tomorrow. And we need to make sure our presence includes the right kind of people—trained political and economic officers who can get out and about to do their job.

By expanding our diplomatic presence in Africa, including outside the capitals, we increase our ability to learn about the continent—its governments, its people and its cultures. Right now, we do not have the necessary human resources or expertise on the African continent to gather this information and anticipate emerging crises or fully understand existing ones. Diplomatic reporting and open source collection in Africa are a critical complement to the clandestine work of the

intelligence community, and I have long called for more resources for both. I have also called for an integrated, interagency collection and analysis strategy, which is why Senator Hagel and I last year introduced legislation to establish an independent commission to address this long-term, systematic problem. This legislation was passed by the Intelligence Committee last year and, although Senator Hagel has retired, I intend to reintroduce this legislation this year.

Developing these capacities and a balanced approach is in our national security interest and is necessary if we are to better address areas of concern in Africa. At present, there are several devastating crises that we cannot ignore, including in Congo, Nigeria, the Sahel, Sudan and Zimbabwe. But I believe one region stands out for its particular significance to our national security, and that is the Horn of Africa and specifically the deepening crisis in Somalia. I would like to spend the rest of my remarks discussing the situation in this region, where the need for a carefully planned and long-term approach is particularly urgent.

During my December trip, I also visited Djibouti. There, I met with many leading figures in Somalia, including the Prime Minister of the Somali Transitional Federal Government, the leadership of the opposition Alliance for the Re-Liberation of Somalia, the UN Special Representative for Somalia, the President of Somaliland and members of Somalia's civil society. I also met with Djiboutian government officials and members of civil society, as well as with our diplomats working on Somalia out of both Djibouti and Nairobi, who are extraordinary and deeply committed individuals.

Tragically, the situation in Somalia continues to get worse. Six months ago I stood on the Senate floor to discuss Somalia's humanitarian crisis—the worst in the world. According to a local human rights group, an estimated 16,000 people have been killed since the start of 2007, with over 28,000 people wounded and more than one million displaced. USAID now estimates that 3.2 million people—soon to be half of the population—are in need of emergency assistance, including hundreds of thousands of refugees in neighboring countries. The stories and images of human suffering coming out of Somalia are horrifying.

In addition to the humanitarian impact, I am deeply concerned by the potential impact of this crisis on our national security. With the Ethiopian army withdrawing, the transitional government remains deadlocked, new militias are forming, and existing ones continue to gain new territory. And while the Somalis are a moderate people, the terrorist group al Shabab has grown in ranks and expanded its reach. Moreover, just last month, several senior officials, including CIA Director Hayden and Joint Chiefs Chairman Mullen, said that al-Qaida is extending its reach in Somalia to revitalize its operations.

The Bush administration's approach to Somalia—endorsing the Ethiopian invasion, backing an unpopular transitional government and launching periodic military strikes in the absence of a broader coherent strategy—was an abject failure. Without a carefully crafted strategy for Somalia, we have long relied on short-sighted tactics and a ''manhunt'' approach, rather than investing fully in efforts to promote a sustainable peace and help build legitimate and inclusive institutions. The result has been increased anti-Americanism, which helps enable extremist groups to effectively recruit and operate.

With the Obama administration now in office, there is a critical opportunity, as well as an urgent need, to identify the lessons of this failed policy and signal a break from the past. One of my top priorities is to work with the Obama administration to develop a new comprehensive interagency strategy to bring stability to Somalia and the wider Horn of Africa. Support for the Djibouti process should continue, but we need to be far sighted about what it will take to translate diplomatic initiatives into security for the people of Somalia. That effort must include efforts from the ground up to build legitimate and inclusive governance institutions that respond to the needs of ordinary Somalis. For only when those institutions take hold will we finally be able to limit the appeal of violent extremism and achieve sustainable peace and security—and bolster our own national security.

IDAHOANS SPEAK OUT ON HIGH ENERGY PRICES

Mr. CRAPO. Mr. President, in mid-June, I asked Idahoans to share with me how high energy prices are affecting their lives, and they responded by the hundreds. The stories, numbering well over 1,200, are heartbreaking and touching. While energy prices have dropped in recent weeks, the concerns expressed remain very relevant. To respect the efforts of those who took the opportunity to share their thoughts, I am submitting every e-mail sent to me through an address set up specifically for this purpose to the CONGRESSIONAL RECORD. This is not an issue that will be easily resolved, but it is one that deserves immediate and serious attention, and Idahoans deserve to be heard. Their stories not only detail their struggles to meet everyday expenses, but also have suggestions and recommendations as to what Congress can do now to tackle this problem and find solutions that last beyond today. I ask unanimous consent to have today's letters printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

You are asking Idahoans to write about gas prices? You mean you do not know? I think Washington D.C. may as well be registered as another planet because I think your colleagues are so far from reality of the rest of the people it is absolutely outrageous.

Your colleague Barbara Boxer of California said that she wants Americans to use alternative routes of transportation and that it is a good thing that gas prices force people to take the bus, ride bikes, or walk to their destination because it helps reduce global warming.

I have something to say to you and to Boxer and you can tell her for me.

I am a driver for a living. I deliver products right here in Boise. I have to drive I have no choice. I am also a salesman, and a night supervisor. To Senator Boxer, I live in Idaho. I do not have the option of riding the bus. I cannot walk my deliveries or ride my bike with my products? Is she insane?

I find it absolutely insulting for her to talk down to me like that. She and her liberal Senators love these high gas prices because they want to use it as an excuse to make us live how they want us to live to fight so-called global warming, while she and Al Gore fly in jets. That's Eco-Socialism in my opinion.

Senator Crapo, I have three jobs. Three jobs. And I am still having problems fueling up. I have had to open credit card accounts for the first time in my life. And my debt is still going up.

You'd think with three jobs and three paychecks for one person. I am not married no kids. I would be starving with fuel prices if I had a family. I am just barely paying my bills on time as they are, to about $1500 a month not including gas prices.

Starting in 2005 till 2007, I did very well financially, I was saving up and putting money away in my savings account. I loved myself for putting money away. This month in June I had to take one-quarter of my life savings out of my bank to pay for bills including gas because the price skyrocketed from $3 to $4 a gallon in one month.

This is outrageous. I am so angry at Congress right now. . . You have no idea.

I think it is 80 percent the Government's fault for this and 20 percent the oil companies. The only thing the oil companies are doing wrong is speculating the price of oil for really dumb reasons. Like if you so much as sneeze the price would go up in panic.

Congress has done this because you refuse to drill for oil in ANWR to save a deer called caribou! Congress is more worried about a stupid deer than they are about my life? More worried about the mating season of the caribou than they are about the economy? My jobs? My gas prices? My bills? My lifestyle? I am sorry I thought you were the people's Congress? Not the caribou's congress! Do we have an animal congress I should know about?

You won't allow drilling off shore? Well did you know that China is drilling for oil off the coast of Florida? But we cannot? Why? This is outrageous.

Do not listen to those radical environmentalists. They were wrong about the second ice age in the 70s. When I was kid in school in the 1980's, my teachers told me by the year 1999 New York would be underwater and Los Angeles would be a bunch of Islands. It has not happened. Of course the earth's temperature changes and jumps over time. The earth's climate changes all the time, has been since the earth cooled and formed. The earth's temperature does not stay the same all the time. There are so many scientists and people who disagree with Al Gore, but if we disagree we are labeled ''flat-earthers'' and ''Holocaust Deniers.'' How dare Al Gore tell me that I have no first amendment right to disagree with him on climate change.

My question for the Republican Party is this. Why did you not approve drilling for oil

when you had Congress lock, stock, and barrel? In 2002, I cheered when the GOP took back the Senate and we had both Houses plus the White House. I yelled, ''Yes! At last we can get some real work done!'' But what have you done with those four years of three Branches with GOP? Nothing! You took your voters for granted and then you were surprised when you lost in 2006.

I have spoken to many Republicans, Moderates, Independents, Moderate Democrats, and Conservatives who are seriously thinking of either staying home or voting Democrat based on the GOP's laziness. Although I do not trust Democrats with the economy, why should we the voters reward Republicans? Give us a reason? Answer . . . gas prices! Point out that it is the Dems who want the price high! Even Barack Obama admitted that he wanted it to go high just not so fast.

Senator Crapo. You want to help me? A person with three jobs and struggling with gas prices? I have not had a vacation since March of 2007! I can't even take a one day vacation to Jackpot anymore! Senator Crapo I work all seven days a week! I get no weekends! And I still struggle to pay gas prices! About $15 a day! Not a week! A day!

Drill here! Drill now! Drill in ANWR! Drill in America!

Tell your friends drill.

AARON BANKS, *Boise.*

Hi. Thank you Senator for your sincere concern for Idaho Residents.

I am 58 next month, and on disability from a very severe fire I was trapped in several years ago.

Though I do get an income, this is where it goes:

Receive $625.00 a month

1. $200.00 a month mobile home space rent
2. $156.00 a month mortgage payments for my mobile home . . . which without the owner of the mobile home, I would not be on my way to being a first time home owner!
3. $48.00 a month mobile home insurance
4. $40.00 a month vehicle insurance . . . it is a 1988 Plymouth Voyager van that I have had since 1988.
5. $39.00 phone bill . . . which was supposed to reduced several months ago through my social worker, an still remains at the normal price and I do not have long distance.
6. $30–40 electricity monthly . . . do not have an air conditioner for summer but do open my windows and use my ceiling fans that helps.
7. $125–and up in winter for gas to run my heater monthly . . . that is after I receive fuel assistance which for some reason only lasts 1–2 months and only use the heater to warm up the area so can start my wood stove which is usually one–half hour.

So if I am lucky, all I can afford to do is put up to $20.00 a month in gas which gives me almost 1/4 tank and that has to last the month.

I have medical problems that mean many trips to the doctor and pharmacy, and with such a low amount of gas I have to depend on others for rides when I run out of gas.

Thank you for your sincere concern and we are all hoping and praying that gas will once again come down to where people like me can afford to purchase more.

LORETTA LOWERRE, *Nampa.*

First of all, I am disappointed that you provide prefixes for all kinds of people except the only class of people (with one exception—MSgt) that have official (not courteous) titles in these United States—the military. My title is Colonel.

Second, from your letter on gas prices that you sent me, you are starting to understand that the Congress holds most of the blame for high oil (and thus gas) prices. Congress has failed to act in the thirty years since the last gas crisis, continually failing to take responsible action to make sure domestic supplies are developed and used to reduce dependence on foreign oil.

It should be clear that the single most deleterious action of Congress over the last forty years was the Environmental Protection Act. It has desperately needed revision since the early seventies and because it was not, the economic impact on America has been extreme. The inability to build domestic gas refineries, increase domestic oil production and take advantage of resources in ANWR are only a few of the unintended and disastrous impacts of that act. An environmentalist has only to write a single letter to cause the price of any such proposal to escalade exponentially. The latest case of the proposed nuclear reactor in Idaho is an example. One man writing one letter can cause the waste of hundreds of thousands of dollars to ''prove'' the lack of environmental impacts of such a proposal.

The price of a house in Idaho has risen by 10–15 percent, for instance, because of the ludicrous and technically flawed environmental studies and reactions on the spotted owl.

Still no action in Congress to alleviate the situation. We simply need someone to stand up and take the actions necessary to replace political correctness with what used to be common sense.

So the bottom line, Senator, is that Congress bears the responsibility to stop passing stupid laws and start reigning in those that are hurting the nation's ability to do the right things rather than the politically correct things. Do you have the courage to start?

ROBERT KEENAN, *Meridian.*

You asked what the high gas prices are doing to me. It has become very difficult to even do normal things. I cannot afford to go up town and buy necessary things. Since I am on Social Security Disability my sister and I have been living off my money. Since my sister does not have a car and I cannot afford to buy one for her, nor could I afford the gas. She would love to go to work. How would she get there? Idaho, and particularly this area has a really horrible public transportation system. It truly is a disgrace to our state. My sister walks as much as possible. Our nation needs to stop depending on foreign oil. I love all the animals and have tried to protect them as much as possible, but we need to start taking care of our families first.

The oil companies are making over the profit margin; that is disgusting by itself. I do not trust one thing they say or do. Therefore, we need to have alternative fuel. The wind can run electricity. The air can fuel a car, water can do both, after seeing the pictures of a car that runs on air. America, the greatest country in the world needs to step up to the plate. Oil companies need to step up to the plate before they become the dinosaurs. Therefore, we need to drill. Do it. Many families like mine are being devastated by the high gasoline prices which makes high food prices we cannot afford. Thank you for your time.

MARIAN RUHLING, *Nampa.*

Hello—This is in response to a solicitation from Senator Crapo regarding personal stories on how high energy prices are affecting lives.

Greed is the source of most of the world's evil. I know I sound like an ideologue, but please read on.

It is hard to disaggregate the effects of the high cost of energy from other economic hits our family is experiencing. When construction activity slowed in Valley and Adams County, wage earning families left our valleys looking for jobs elsewhere. So long, Tamarack?

The resulting reduced school enrollment (now compounded by the end of Craig-Wyden) in our districts led me to being one of the teachers RIF'd from the Council School District. Fortunately, I found work part-time in the McCall School District. Unfortunately, this 70 mile, round-trip commute (in my 2000 140,000+ mile Dodge AWD Caravan—needed for unpredictable roads) costs me $9.00–$12.00 a trip! I would like to buy a more fuel efficient Subaru—but I cannot afford to.)

My school-age children suffer because programs are being severely reduced—Shop and Art are gone. Some high school courses will only be offered every other year. Summer school for poor learners is truncated. Field trips? Sports? Are you kidding? Both are severely reduced. How can our small-town children go out and experience the world when there isn't even money for gas?

As consumers, our family lives so far from ''the source'' that not only gas, but also milk and other basic commodities seem to cost at least 25 percent more than they did a year ago. Last year I was able to find milk for $2.29 gallon; now milk costs close to $4.00/gallon. Healthy bread costs close to $4.00/loaf. As a family, we certainly have not received a COLA to offset these price increases.

As middle-class professionals (my husband is a forester) and as parents, the drain on our budget means belt-tightening for any of ''fun things'' like vacation trips. Additionally, we have experienced a health crisis (and have met our catastrophic limits). I now must commute to Fruitland (140 miles round trip) every 2 weeks for chemo; in the fall I will need to commute 5 days a week for radiation for 6 weeks! (My doctor cavalierly denied me two prescriptions for drugs since they are also available OTC. ''They only cost a few dollars. '' He casually shrugged off my request for RXs. Well, the two drugs cost more than $30 altogether. I do not think that the upper-middle-class and upper-class have a clue that there is an exponential difference between a few bucks (a latte) and $30—a chance to visit a museum or movie, or halfway fill up a gas tank to make it to a chemo session!)

I believe that our tax system rewards the rich on the backs of the poor and middle class. I believe that oil companies and owners of stocks are making fortunes as the little guy suffers.

I believe we should take global warning seriously and allow tax credits for the development of alternative energy. We need to take recycling very seriously. We also need to be a world economic partner on a fair playing field (Kyoto convention), quit out-sourcing to countries that do not provide the labor protections we do to our workers, and build respectful relationships among all peoples and all cultures—as a first step to world peace and understanding and a step away from the ugliness of war.

I also believe that limiting population growth and sharing the world's resource's equably is the only way we will ever establish peace on earth.

Locally, for our family, what have been the effects of high energy costs? Higher food and medical costs, loss of job, reduced school programs for my children, dwindled savings, ''making do'' with older cars and housing needs, fewer amenities, no vacation.

Glad you asked.

LYNN, *Fruitvale.*

I read your letter sent out today.

Glad to hear that at least one of our Senators in Washington gets it. I hope there are

more of you in DC that can support the policies you want to support in your letter.

We do need to start drilling again in the US and Off-Shore. We need to make sure that we take precautions to avoid damage to the environment. We cannot sacrifice one for the other. But we must start drilling again, and do so in a respective manner of Mother Nature.

And we are going to need some new refining capability. Again, do it new technology and with respect to our environment. Build it in Eastern Idaho—we have the space and we could use the jobs and economic boost. Tough to get oil here, but if they need a place for it, bring it here.

We must start the nuclear programs again. We need to build some new reactors soon. I do not know for sure, but I am betting some of our older reactors are getting long in the tooth, and if they go off the grid, then what happens? Besides we need more power and money spent to renew our grid system.

We need to take a serious look at Ethanol. I am not sure it is all it is being promoted to be. I am not sure the benefits outweigh all of the costs. With the flooding in the Midwest, I wonder what the cost of corn will be now? But it is not just food issues, but the processing issues as well.

Wind Power should be promoted as well. But a Nuclear Power Plant is much easier on the eyes than 1000 wind towers, and not as susceptible to the changes in the wind.

Coal alternatives should be looked at as well. We need to check if the benefits we can gain from technology like coal gasification are valid and have low impact. Some of the claims you hear and read about look promising. But as I am learning with Ethanol, there may be some significant costs to chase this type of technology.

But the short of it—we need to develop our energy and become more independent. The amount of jobs created would be incredible in the process. You want a better health care system and less unemployment and less government care programs—just set the energy companies loose (for a change) and see this economy rebound in a heartbeat. These energy companies can afford health care plans and benefits for their workers. Our current policies are killing us—and I really hope there are enough Senators and Representatives in DC to turn this around. We have been shooting ourselves in the foot for more than 20 years. Guess it took that long for the ''brain'' to finally realize the pain in doing so.

Good Luck.

STEPHEN KAISER, *Rigby*.

TRIBUTE TO ARDIS DUMETT

Mrs. MURRAY. Mr. President, I rise today to recognize Ardis Dumett for her 20 years of service to the U.S. Senate and the people of Washington State. Ardis has served on my staff for the last 16 years of her distinguished public career. For 4 years prior to her service in my office, she worked for the revered Senator Henry ''Scoop'' Jackson. On January 20, Ardis retired from my office. We are sad to see her go and hope that she enjoys her well-earned retirement.

Throughout her career, Ardis has been a thoughtful and dedicated public servant. Initially, as my constituent services director, she led by example in her commitment and compassion to the constituents of Washington State. Covering immigration and environmental casework, she ensured the people of my State were well served by their Federal Government.

As the director of special projects in my Seattle office, she worked on numerous issues on my behalf over the years, ranging from the environment and emergency response to tribes and the transfer of military property. She worked tirelessly to guarantee that our State's people and communities received a fair process—and often a successful outcome—when working with Federal agencies. Over the years I have received many notes from constituents thanking me for Ardis' diligent work.

I would like to thank Ardis for her years of service to me and the people of Washington State. Her career is a tremendous example of public service; and her dedication to her work is truly appreciated. I wish her all the best in her future endeavors.

ADDITIONAL STATEMENTS

UNI-CAPITOL WASHINGTON INTERNSHIP PROGRAMME 2009

• Mr. CRAPO. Mr. President, I am proud to be involved for a third year in the Uni-Capitol Washington Internship Programme, UCWIP, an exchange program in which outstanding college students from Australia's top universities compete to serve as interns for the U.S. Congress. The program is in its 10th year of bringing the Washington experience to our friends from Australia, firsthand. In addition to working in congressional offices, the program provides students with a number of other opportunities and activities including visits to historic sites, visits to government agencies, meetings with government leaders, and educational events.

This year, Nicholas Tam, a student from Melbourne University in Australia, is taking a 2-month hiatus from his law degree to help me serve Idaho constituents. Of the program, Nick says, ''Working with Senator CRAPO has been a gateway to developing a nuanced, sophisticated understanding of the United States and its precise position and role in the world. UCWIP has been culturally enriching and enhancing of my own professional development. It has been a real privilege to aid in the advancement of strong conservative principles whilst working here in the United States Senate.'' Nick is a terrific temporary addition to my staff and, like past interns, an intelligent individual, hard worker and personable.

Director Eric Federing and his wife Daphne have shown a decade of tireless commitment to enlarging the educational experience of Australian students. Now with 81 program alumni, this educational and highly successful exchange program has earned a rightful place among leading international academic exchange opportunities. I am honored to continue to participate in this well-crafted and successful program.•

MESSAGE FROM THE PRESIDENT

A message from the President of the United States was communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGE REFERRED

As in executive session the Presiding Officer laid before the Senate a message from the President of the United States submitting a nomination which was referred to the Committee on Foreign Relations.

(The nomination received today is printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 4:52 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bill, without amendment:

S. 181. An act to amend title VII of the Civil Rights Act of 1964 and the Age Discrimination in Employment Act of 1967, and to modify the operation of the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, to clarify that a discriminatory compensation decision or other practice that is unlawful under such Acts occurs each time compensation is paid pursuant to the discriminatory compensation decision or other practice, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 26. Concurrent resolution providing for an adjournment of the House.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–547. A communication from the General Counsel, Federal Housing Finance Agency, transmitting, pursuant to law, the report of a rule entitled ''Golden Parachute Payments'' (RIN2590–AA08) received in the Office of the President of the Senate on January 24, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–548. A communication from the Chief of Staff, Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendment of Section 73.622(i), Final DTV Table of Allotments, Television Broadcast Stations; Rio Grande City, Texas'' (MB Docket No. 08–141) received in the Office of the President of the Senate on January 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–549. A communication from the Chief of Staff, Media Bureau, Federal Communications Commission, transmitting, pursuant to law, the report of a rule entitled ''Implementation of Short-term Analog Flash and Emergency Readiness Act; Establishment of DTV Transition 'Analog Nightlight' Program'' (MB Docket No. 08–255) received in the Office of the President of the Senate on January 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–550. A communication from the Acting Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, a report relative to the certification to Congress on the effectiveness of

the Australia Group; to the Committee on Foreign Relations.

EC–551. A communication from the Principal Deputy Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, the quarterly report of the Department of Justice's Office of Privacy and Civil Liberties; to the Committee on the Judiciary.

EC–552. A communication from the Principal Deputy Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, a report entitled ''Secure Our Schools Program, FY 2008—Annual Report to Congress''; to the Committee on the Judiciary.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. INOUYE, from the Committee on Appropriations, without amendment:

S. 336. An original bill making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes (Rept. No. 111–3).

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. LEVIN for the Committee on Armed Services.

Air Force nominations beginning with Brigadier General Donald A. Haught and ending with Colonel William M. Ziegler, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Brig. Gen. John M. Croley and ending with Brig. Gen. Tracy L. Garrett, which nominations were received by the Senate and appeared in the Congressional Record on January 8, 2009.

Army nominations beginning with Brigadier General Peter M. Aylward and ending with Colonel Michael T. White, which nominations were received by the Senate and appeared in the Congressional Record on January 14, 2009.

Mr. LEVIN. Mr. President, for the Committee on Armed Services I report favorably the following nomination lists which were printed in the RECORDs on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

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

Air Force nomination of Edmund P. Zynda II, to be Major.

Air Force nomination of Daniel C. Gibson, to be Major.

Air Force nominations beginning with Donald L. Marshall and ending with Charles E. Peterson, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nominations beginning with Paul J. Cushman and ending with Luis F. Sambolin, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nominations beginning with Christopher S. Allen and ending with Deepa Hariprasad, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nomination of Ryan R. Pendleton, to be Lieutenant Colonel.

Air Force nomination of Howard L. Duncan, to be Lieutenant Colonel.

Air Force nominations beginning with Jeffrey R. Grunow and ending with Pamela T. Scott, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nomination of Eugene M. Gaspard, to be Colonel.

Air Force nominations beginning with Michael R. Powell and ending with Valerie R. Taylor, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nominations beginning with Mary Elizabeth Brown and ending with Gerald J. Laursen, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nominations beginning with Gary R. Califf and ending with C. Michael Padazinski, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nominations beginning with Stephen Scott Baker and ending with Phillip E. Parker, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nominations beginning with Joseph Allen Banna and ending with Joseph Tock, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Air Force nominations beginning with Keith A. Acree and ending with Steven L. Youssi, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nomination of Scott A. Gronewold, to be Colonel.

Army nominations beginning with Robert L. Kaspar, Jr. and ending with David K. Scales, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nomination of Emmett W. Mosley, to be Colonel.

Army nominations beginning with Andrew C. Meverden and ending with April M. Snyder, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nominations beginning with Douglas M. Coldwell and ending with Stephen Montaldi, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nomination of Thomas S. Carey, to be Major.

Army nomination of Scottie M. Eppler, to be Major.

Army nomination of Pierre R. Pierce, to be Major.

Army nominations beginning with Cheryl A. Creamer and ending with Aga E. Kirby, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nominations beginning with Kathryn A. Belill and ending with Suzanne R. Todd, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nominations beginning with Christopher Allen and ending with D060522, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nominations beginning with John L. Ament and ending with Wendy G. Woodall, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Army nominations beginning with Terryl L. Aitken and ending with Sarahtyah T. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nomination of Matthew E. Sutton, to be Lieutenant Colonel.

Marine Corps nomination of Andrew N. Sullivan, to be Lieutenant Colonel.

Marine Corps nomination of Tracy G. Brooks, to be Lieutenant Colonel.

Marine Corps nominations beginning with Peter M. Barack, Jr. and ending with Jacob D. Leighty III, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with David G. Boone and ending with James A. Jones, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with William A. Burwell and ending with Balwindar K. Rawalayvandevoort, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Kurt J. Hastings and ending with Calvin W. Smith, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with James P. Miller, Jr. and ending with Marc Tarter, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nomination of David S. Pummell, to be Major.

Marine Corps nomination of Robert M. Manning, to be Major.

Marine Corps nomination of Michael A. Symes, to be Major.

Marine Corps nomination of Paul A. Shirley, to be Major.

Marine Corps nomination of Richard D. Kohler, to be Major.

Marine Corps nominations beginning with Julie C. Hendrix and ending with Mauro Morales, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Christopher N. Norris and ending with Samuel W. Spencer III, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Anthony M. Nesbit and ending with Paul Zacharzuk, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Gregory R. Biehl and ending with Bryan S. Teet, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Travis R. Avent and ending with Gregg R. Edwards, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Jose A. Falche and ending with Clennon Roe III, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Keith D. Burgess and ending with Brian J. Spooner, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Mark L. Hobin and ending with Terry G. Norris, which nominations were received by

the Senate and appeared in the Congressional Record on January 7, 2009.

Marine Corps nominations beginning with Kevin J. Anderson and ending with Edward P. Wojnaroski, Jr., which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

Navy nomination of Steven J. Shauberger, to be Lieutenant Commander.

Navy nomination of Karen M. Stokes, to be Lieutenant Commander.

Navy nominations beginning with Craig W. Aimone and ending with Matthew M. Wills, which nominations were received by the Senate and appeared in the Congressional Record on January 7, 2009.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. DURBIN (for himself, Mr. WHITEHOUSE, Mr. AKAKA, Mr. BROWN, and Mr. SANDERS):

S. 330. A bill to amend title XVIII of the Social Security Act to deliver a meaningful benefit and lower prescription drug prices under the Medicare program; to the Committee on Finance.

By Mr. SCHUMER (for himself, Mr. SHELBY, Mr. DURBIN, Mrs. FEINSTEIN, Mr. BAYH, Mr. TESTER, Mr. GRAHAM, Mr. SESSIONS, and Mr. ROBERTS):

S. 331. A bill to increase the number of Federal law enforcement officials investigating and prosecuting financial fraud; to the Committee on the Judiciary.

By Mrs. FEINSTEIN (for herself and Mr. BROWNBACK):

S. 332. A bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner; to the Committee on Health, Education, Labor, and Pensions.

By Ms. MIKULSKI (for herself, Ms. STABENOW, Mr. CARDIN, and Mr. WEBB):

S. 333. A bill to amend the Internal Revenue Code of 1986 to allow an above-the-line deduction against individual income tax for interest on indebtedness and for State sales and excise taxes with respect to the purchase of certain motor vehicles; to the Committee on Finance.

By Mr. LUGAR:

S. 334. A bill to authorize the extension of nondiscriminatory treatment (normal trade relations treatment) to the products of Moldova; to the Committee on Finance.

By Mrs. GILLIBRAND:

S. 335. A bill to amend part D of title IV of the Social Security Act to repeal a fee imposed by States on certain child support collections; to the Committee on Finance.

By Mr. INOUYE:

S. 336. An original bill making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes; from the Committee on Appropriations; placed on the calendar.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. VITTER (for himself and Ms. LANDRIEU):

S. Res. 22. A resolution recognizing the goals of Catholic Schools Week and honoring the valuable contributions of Catholic schools in the United States; considered and agreed to.

By Mr. CASEY (for himself, Mr. SPECTER, Ms. SNOWE, and Ms. COLLINS):

S. Res. 23. A resolution honoring the life of Andrew Wyeth; considered and agreed to.

ADDITIONAL COSPONSORS

S. 66

At the request of Mr. INOUYE, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 66, a bill to amend title 10, United States Code, to permit former members of the Armed Forces who have a service-connected disability rated as total to travel on military aircraft in the same manner and to the same extent as retired members of the Armed Forces are entitled to travel on such aircraft.

S. 85

At the request of Mr. VITTER, the name of the Senator from Oklahoma (Mr. COBURN) was added as a cosponsor of S. 85, a bill to amend title X of the Public Health Service Act to prohibit family planning grants from being awarded to any entity that performs abortions.

S. 96

At the request of Mr. VITTER, the name of the Senator from Oklahoma (Mr. COBURN) was added as a cosponsor of S. 96, a bill to prohibit certain abortion-related discrimination in governmental activities.

S. 133

At the request of Mrs. FEINSTEIN, the name of the Senator from South Dakota (Mr. THUNE) was added as a cosponsor of S. 133, a bill to prohibit any recipient of emergency Federal economic assistance from using such funds for lobbying expenditures or political contributions, to improve transparency, enhance accountability, encourage responsible corporate governance, and for other purposes.

S. 213

At the request of Mrs. BOXER, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 213, a bill to amend title 49, United States Code, to ensure air passengers have access to necessary services while on a grounded air carrier, and for other purposes.

S. 256

At the request of Mrs. FEINSTEIN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 256, a bill to enhance the ability to combat methamphetamine.

S. 271

At the request of Ms. CANTWELL, the names of the Senator from California (Mrs. BOXER), the Senator from Rhode Island (Mr. REED) and the Senator from Rhode Island (Mr. WHITEHOUSE) were added as cosponsors of S. 271, a bill to amend the Internal Revenue Code of 1986 to provide incentives to accelerate the production and adoption of plug-in electric vehicles and related component parts.

S. 298

At the request of Mr. ISAKSON, the names of the Senator from Texas (Mr. CORNYN) and the Senator from Idaho (Mr. RISCH) were added as cosponsors of S. 298, a bill to establish a Financial Markets Commission, and for other purposes.

S. 326

At the request of Mr. MCCONNELL, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 326, a bill to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program through fiscal year 2013, and for other purposes.

S. 328

At the request of Mr. ROCKEFELLER, the names of the Senator from Arkansas (Mr. PRYOR), the Senator from Wisconsin (Mr. KOHL), the Senator from Vermont (Mr. SANDERS), the Senator from Pennsylvania (Mr. CASEY) and the Senator from Iowa (Mr. HARKIN) were added as cosponsors of S. 328, a bill to postpone the DTV transition date.

S. RES. 9

At the request of Mr. LUGAR, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. Res. 9, a resolution commemorating 90 years of U.S.-Polish diplomatic relations, during which Poland has proven to be an exceptionally strong partner to the United States in advancing freedom around the world.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN (for himself, Mr. WHITEHOUSE, Mr. AKAKA, Mr. BROWN, and Mr. SANDERS):

S. 330. A bill to amend title XVIII of the Social Security Act to deliver a meaningful benefit and lower prescription drug prices under the Medicare program; to the Committee on Finance.

Mr. DURBIN. Mr. President, in the 6 years since Congress passed the Medicare Modernization Act, life for seniors has become increasingly difficult. The majority of seniors live on a fixed income, but face the challenge of paying more with less as the costs for everything continue to rise. Housing costs, basic nutrition, and healthcare needs are more expensive.

The addition of a prescription drug benefit to Medicare was long overdue, and many senior citizens and people with disabilities are relieved to finally have drug coverage. But the drug benefit was not structured like the rest of Medicare. For all other Medicare benefits, seniors can choose whether to receive benefits directly through Medicare or through a private insurance plan. The overwhelming majority choose the Medicare-run option for their hospital and physician coverage.

Unfortunately, no such choice is available for prescription drugs. Medicare beneficiaries must enroll in a private insurance plan to obtain drug coverage and with that are subjected to the multiple changes drug plans are allowed to impose on seniors year after year.

Each drug plan has its own premium, cost-sharing requirements, list of covered drugs, and pharmacy network. After you have identified the right drug plan, you have to go through the whole process again at the end of the year because your plan may have changed the drugs it covers or added new restrictions on how to access covered drugs.

Seniors are having trouble identifying which of the dozens of private drug plans works best for them. The complexity of the program has made beneficiaries more vulnerable to aggressive and deceptive marketing practices as some insurers try to steer seniors into more profitable Medicare Advantage plans. Some seniors have been signed up for Medicare Advantage plans without their knowledge, and, unfortunately, there have also been dishonest insurance agents who have misrepresented what benefits would be covered. Anyone who has visited a senior center or spoken with an elderly relative knows that the complexity of the drug benefit has created much confusion.

Drug plans often do not tell beneficiaries that they can appeal a drug plan's decision to deny coverage for a drug, even though they are required to do so. Beneficiaries who do appeal soon find that it is a long and difficult process.

Multiple studies have shown that private drug plans have not been effective negotiators, which means seniors end up paying more than they should. A report by Avalere Health released in late 2008 revealed that the average beneficiary will see a 24 percent increase in their monthly premiums for 2009. The top 10 most popular plans by enrollment will increase their premiums by more than 30 percent.

Today, I am introducing the Medicare Prescription Drug Savings and Choice Act. The bill would create a Medicare-operated drug plan that would compete with private drug plans and would give the Health and Human Services Secretary leverage to negotiate with drug companies to lower drug prices.

The Health and Human Services Secretary would have the tools to negotiate with drug companies, including the use of drug formulary. The best medical evidence would determine which drugs are covered in the formulary, and the formulary would be used to promote safety, appropriate use of drugs, and value.

The bill would establish an appeals process that is efficient, imposes minimal administrative burdens, and ensures timely procurement of non-formulary drugs or non-preferred drugs when medically necessary.

This is the kind of drug plan that Medicare beneficiaries are looking for. According to a survey by the Kaiser Family Foundation, two-thirds of seniors want the option of getting drug coverage directly from Medicare, and over 80 percent favor allowing the Government to negotiate with drug companies for lower prices.

Seniors want the ability to choose a Medicare-administered drug plan and deserve a simpler, more dependable, and less costly program that prioritizes their needs. Let's give them this option—just as they have this choice with every other benefit covered by Medicare.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 330

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Prescription Drug Savings and Choice Act of 2009''.

SEC. 2. ESTABLISHMENT OF MEDICARE OPERATED PRESCRIPTION DRUG PLAN OPTION.

(a) IN GENERAL.—Subpart 2 of part D of the Social Security Act is amended by inserting after section 1860D–11 (42 U.S.C. 1395w–111) the following new section:

''MEDICARE OPERATED PRESCRIPTION DRUG PLAN OPTION

''SEC. 1860D–11A. (a) IN GENERAL.—Notwithstanding any other provision of this part, for each year (beginning with 2010), in addition to any plans offered under section 1860D–11, the Secretary shall offer one or more medicare operated prescription drug plans (as defined in subsection (c)) with a service area that consists of the entire United States and shall enter into negotiations in accordance with subsection (b) with pharmaceutical manufacturers to reduce the purchase cost of covered part D drugs for eligible part D individuals who enroll in such a plan.

''(b) NEGOTIATIONS.—Notwithstanding section 1860D–11(i), for purposes of offering a medicare operated prescription drug plan under this section, the Secretary shall negotiate with pharmaceutical manufacturers with respect to the purchase price of covered part D drugs in a Medicare operated prescription drug plan and shall encourage the use of more affordable therapeutic equivalents to the extent such practices do not override medical necessity as determined by the prescribing physician. To the extent practicable and consistent with the previous sentence, the Secretary shall implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, including the use of a formulary and formulary incentives in subsection (e), to reduce the purchase cost of covered part D drugs.

''(c) MEDICARE OPERATED PRESCRIPTION DRUG PLAN DEFINED.—For purposes of this part, the term 'medicare operated prescription drug plan' means a prescription drug plan that offers qualified prescription drug coverage and access to negotiated prices described in section 1860D–2(a)(1)(A). Such a plan may offer supplemental prescription drug coverage in the same manner as other qualified prescription drug coverage offered by other prescription drug plans.

''(d) MONTHLY BENEFICIARY PREMIUM.—

''(1) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The monthly beneficiary premium for qualified prescription drug coverage and access to negotiated prices described in section 1860D–2(a)(1)(A) to be charged under a medicare operated prescription drug plan shall be uniform nationally. Such premium for months in 2010 and each succeeding year shall be based on the average monthly per capita actuarial cost of offering the medicare operated prescription drug plan for the year involved, including administrative expenses.

''(2) SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—Insofar as a medicare operated prescription drug plan offers supplemental prescription drug coverage, the Secretary may adjust the amount of the premium charged under paragraph (1).

''(e) USE OF A FORMULARY AND FORMULARY INCENTIVES.—

''(1) IN GENERAL.—With respect to the operation of a medicare operated prescription drug plan, the Secretary shall establish and apply a formulary (and may include formulary incentives described in paragraph (2)(C)(ii)) in accordance with this subsection in order to—

''(A) increase patient safety;

''(B) increase appropriate use and reduce inappropriate use of drugs; and

''(C) reward value.

''(2) DEVELOPMENT OF INITIAL FORMULARY.—

''(A) IN GENERAL.—In selecting covered part D drugs for inclusion in a formulary. the Secretary shall consider clinical benefit and price.

''(B) ROLE OF AHRQ.—The Director of the Agency for Healthcare Research and Quality shall be responsible for assessing the clinical benefit of covered part D drugs and making recommendations to the Secretary regarding which drugs should be included in the formulary. In conducting such assessments and making such recommendations, the Director shall—

''(i) consider safety concerns including those identified by the Federal Food and Drug Administration;

''(ii) use available data and evaluations, with priority given to randomized controlled trials, to examine clinical effectiveness, comparative effectiveness, safety, and enhanced compliance with a drug regimen;

''(iii) use the same classes of drugs developed by United States Pharmacopeia for this part;

''(iv) consider evaluations made by—

''(I) the Director under section 1013 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

''(II) other Federal entities, such as the Secretary of Veterans Affairs; and

''(III) other private and public entities, such as the Drug Effectiveness Review Project and Medicaid programs; and

''(v) recommend to the Secretary—

''(I) those drugs in a class that provide a greater clinical benefit, including fewer safety concerns or less risk of side-effects, than another drug in the same class that should be included in the formulary;

''(II) those drugs in a class that provide less clinical benefit, including greater safety concerns or a greater risk of side-effects, than another drug in the same class that should be excluded from the formulary; and

''(III) drugs in a class with same or similar clinical benefit for which it would be appropriate for the Secretary to competitively bid (or negotiate) for placement on the formulary.

''(C) CONSIDERATION OF AHRQ RECOMMENDATIONS.—

''(i) IN GENERAL.—The Secretary, after taking into consideration the recommendations under subparagraph (B)(v), shall establish a

formulary, and formulary incentives, to encourage use of covered part D drugs that—

''(I) have a lower cost and provide a greater clinical benefit than other drugs;

''(II) have a lower cost than other drugs with same or similar clinical benefit; and

''(III) drugs that have the same cost but provide greater clinical benefit than other drugs.

''(ii) FORMULARY INCENTIVES.—The formulary incentives under clause (i) may be in the form of one or more of the following:

''(I) Tiered copayments.

''(II) Reference pricing.

''(III) Prior authorization.

''(IV) Step therapy.

''(V) Medication therapy management.

''(VI) Generic drug substitution.

''(iii) FLEXIBILITY.—In applying such formulary incentives the Secretary may decide not to impose any cost-sharing for a covered part D drug for which—

''(I) the elimination of cost sharing would be expected to increase compliance with a drug regimen; and

''(II) compliance would be expected to produce savings under part A or B or both.

''(3) LIMITATIONS ON FORMULARY.—In any formulary established under this subsection, the formulary may not be changed during a year, except—

''(A) to add a generic version of a covered part D drug that entered the market;

''(B) to remove such a drug for which a safety problem is found; and

''(C) to add a drug that the Secretary identifies as a drug which treats a condition for which there has not previously been a treatment option or for which a clear and significant benefit has been demonstrated over other covered part D drugs.

''(4) ADDING DRUGS TO THE INITIAL FORMULARY.—

''(A) USE OF ADVISORY COMMITTEE.—The Secretary shall establish and appoint an advisory committee (in this paragraph referred to as the 'advisory committee')—

''(i) to review petitions from drug manufacturers, health care provider organizations, patient groups, and other entities for inclusion of a drug in, or other changes to, such formulary; and

''(ii) to recommend any changes to the formulary established under this subsection.

''(B) COMPOSITION.—The advisory committee shall be composed of 9 members and shall include representatives of physicians, pharmacists, and consumers and others with expertise in evaluating prescription drugs. The Secretary shall select members based on their knowledge of pharmaceuticals and the Medicare population. Members shall be deemed to be special Government employees for purposes of applying the conflict of interest provisions under section 208 of title 18, United States Code, and no waiver of such provisions for such a member shall be permitted.

''(C) CONSULTATION.—The advisory committee shall consult, as necessary, with physicians who are specialists in treating the disease for which a drug is being considered.

''(D) REQUEST FOR STUDIES.—The advisory committee may request the Agency for Healthcare Research and Quality or an academic or research institution to study and make a report on a petition described in subparagraph (A)(ii) in order to assess—

''(i) clinical effectiveness;

''(ii) comparative effectiveness;

''(iii) safety; and

''(iv) enhanced compliance with a drug regimen.

''(E) RECOMMENDATIONS.—The advisory committee shall make recommendations to the Secretary regarding—

''(i) whether a covered part D drug is found to provide a greater clinical benefit, including fewer safety concerns or less risk of side-effects, than another drug in the same class that is currently included in the formulary and should be included in the formulary;

''(ii) whether a covered part D drug is found to provide less clinical benefit, including greater safety concerns or a greater risk of side-effects, than another drug in the same class that is currently included in the formulary and should not be included in the formulary; and

''(iii) whether a covered part D drug has the same or similar clinical benefit to a drug in the same class that is currently included in the formulary and whether the drug should be included in the formulary.

''(F) LIMITATIONS ON REVIEW OF MANUFACTURER PETITIONS.—The advisory committee shall not review a petition of a drug manufacturer under subparagraph (A)(ii) with respect to a covered part D drug unless the petition is accompanied by the following:

''(i) Raw data from clinical trials on the safety and effectiveness of the drug.

''(ii) Any data from clinical trials conducted using active controls on the drug or drugs that are the current standard of care.

''(iii) Any available data on comparative effectiveness of the drug.

''(iv) Any other information the Secretary requires for the advisory committee to complete its review.

''(G) RESPONSE TO RECOMMENDATIONS.—The Secretary shall review the recommendations of the advisory committee and if the Secretary accepts such recommendations the Secretary shall modify the formulary established under this subsection accordingly. Nothing in this section shall preclude the Secretary from adding to the formulary a drug for which the Director of the Agency for Healthcare Research and Quality or the advisory committee has not made a recommendation.

''(H) NOTICE OF CHANGES.—The Secretary shall provide timely notice to beneficiaries and health professionals about changes to the formulary or formulary incentives.

''(f) INFORMING BENEFICIARIES.—The Secretary shall take steps to inform beneficiaries about the availability of a Medicare operated drug plan or plans including providing information in the annual handbook distributed to all beneficiaries and adding information to the official public Medicare website related to prescription drug coverage available through this part.

''(g) APPLICATION OF ALL OTHER REQUIREMENTS FOR PRESCRIPTION DRUG PLANS.—Except as specifically provided in this section, any Medicare operated drug plan shall meet the same requirements as apply to any other prescription drug plan, including the requirements of section 1860D–4(b)(1) relating to assuring pharmacy access).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1860D–3(a) of the Social Security Act (42 U.S.C. 1395w–103(a)) is amended by adding at the end the following new paragraph:

''(4) AVAILABILITY OF THE MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—A medicare operated prescription drug plan (as defined in section 1860D–11A(c)) shall be offered nationally in accordance with section 1860D–11A.''.

(2)(A) Section 1860D–3 of the Social Security Act (42 U.S.C. 1395w–103) is amended by adding at the end the following new subsection:

''(c) PROVISIONS ONLY APPLICABLE IN 2006, 2007, 2008, AND 2009.—The provisions of this section shall only apply with respect to 2006, 2007, 2008, and 2009.''.

(B) Section 1860D–11(g) of such Act (42 U.S.C. 1395w–111(g)) is amended by adding at the end the following new paragraph:

''(8) NO AUTHORITY FOR FALLBACK PLANS AFTER 2009.—A fallback prescription drug plan shall not be available after December 31, 2009.''.

(3) Section 1860D–13(c)(3) of such Act (42 U.S.C. 1395w–113(c)(3)) is amended—

(A) in the heading, by inserting ''AND MEDICARE OPERATED PRESCRIPTION DRUG PLANS'' after ''FALLBACK PLANS''; and

(B) by inserting ''or a medicare operated prescription drug plan'' after ''a fallback prescription drug plan''.

(4) Section 1860D–16(b)(1) of such Act (42 U.S.C.1395w–116(b)(1)) is amended—

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

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

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

''(E) payments for expenses incurred with respect to the operation of medicare operated prescription drug plans under section 1860D–11A.''.

(5) Section 1860D–41(a) of such Act (42 U.S.C. 1395w–151(a)) is amended by adding at the end the following new paragraph:

''(19) MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—The term 'medicare operated prescription drug plan' has the meaning given such term in section 1860D–11A(c).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

SEC. 3. IMPROVED APPEALS PROCESS UNDER THE MEDICARE OPERATED PRESCRIPTION DRUG PLAN.

Section 1860D–4(h) of the Social Security Act (42 U.S.C. 1305w–104(h)) is amended by adding at the end the following new paragraph:

''(4) APPEALS PROCESS FOR MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—

''(A) IN GENERAL.—The Secretary shall develop a well-defined process for appeals for denials of benefits under this part under the medicare operated prescription drug plan. Such process shall be efficient, impose minimal administrative burdens, and ensure the timely procurement of non-formulary drugs or exemption from formulary incentives when medically necessary. Medical necessity shall be based on professional medical judgment, the medical condition of the beneficiary, and other medical evidence. Such appeals process shall include—

''(i) an initial review and determination made by the Secretary; and

''(ii) for appeals denied during the initial review and determination, the option of an external review and determination by an independent entity selected by the Secretary.

''(B) CONSULTATION IN DEVELOPMENT OF PROCESS.—In developing the appeals process under subparagraph (A), the Secretary shall consult with consumer and patient groups, as well as other key stakeholders to ensure the goals described in subparagraph (A) are achieved.''.

By Mrs. FEINSTEIN (for herself and Mr. BROWNBACK):

S. 332. A bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner; to the Committee on Health, Education, Labor, and Pensions.

Mrs. FEINSTEIN. Mr. President, I rise to introduce the Lung Cancer Mortality Reduction Act, calling for a new effort to combat this often deadly form of cancer. I am pleased to be joined by Senator BROWNBACK, the Co-Chair of

the Senate Cancer Coalition, and a strong voice on a variety of cancer issues.

This bill will renew and improve the Federal Government's efforts to combat lung cancer. It will affirm the goal of a 50 percent reduction in lung cancer mortality by 2015.

It will authorize a Lung Cancer Mortality Reduction Program, with interagency coordination, to develop and implement a plan to meet this goal.

It will authorize $75 million for lung cancer research programs in the National Heart Lung Blood Institute, National Institute of Biomedical Imaging and Bioengineering, National Institute of Environmental Health Sciences, and Centers for Disease Control.

It will create a new incentive program in the Food and Drug Administration to be modeled on the Orphan Drug Act for the development of chemoprevention drugs for lung cancer and precancerous lung disease. These are drugs that could prevent precancer from progressing into full-blown disease.

It will improve coordination disparity programs to ensure that the burdens of lung cancer on minority populations are addressed.

We have made great strides against many types of cancer in the last several decades. However, these gains are uneven.

When the National Cancer Act was passed in 1971, lung cancer had a 5-year survival rate of only 12 percent. After decades of research efforts and scientific advances, this survival rate remains only 15 percent. In contrast, the 5-year survival rates of breast, prostate, and colon cancer have risen to 89 percent, 99 percent and 65 percent respectively.

A lung cancer diagnosis can be devastating. The average life expectancy following a lung cancer diagnosis is only 9 months.

This is because far too many patients are not diagnosed with lung cancer until it has progressed to the later stages. Lung cancer can be hard to diagnose, and symptoms may at first appear to be other illnesses. As a result, only 16 percent of lung cancer patients are diagnosed when their cancer is still localized, and is the most treatable.

Lung cancer still lacks early detection technology, to find cancer when it is most treatable. Mammograms can find breast cancer, and colonoscopies can find dangerous colon polyps. But there is no equivalent test for lung cancer at this time.

Under this legislation, the National Cancer Institute has clear authority to work with other institutes on this early detection research. Coordination between all branches of the National Institutes of Health, including those with expertise on lungs, imaging, and cancer will be necessary to make this long overdue progress.

Lung cancer lags behind other cancers, in part, due to stigma from smoking. Make no mistake, tobacco use causes the majority of lung cancer cases. Tobacco cessation is a critical component of reducing lung cancer mortality. Less smoking means less lung cancer. Period.

But tobacco use does not fully explain lung cancer. Approximately 15 percent of the people who die from lung cancer never smoked. A study published in the Journal of Clinical Oncology in 2007 tracked the incidence of lung cancer in 1 million people ages 40 to 79. It found that about 20 percent of female lung cancer patients were nonsmokers and 8 percent of male patients were nonsmokers.

These patients may have been exposed to second hand smoke, or they may have been exposed to radon, asbestos, chromium, or other chemicals. There could be other causes and associations that have not yet been discovered, genetic predispositions or other environmental exposures.

Dana Reeve put a face on these statistics, with her brave fight against lung cancer. Dana Reeve was a nonsmoker, and still was diagnosed with lung cancer at the age of 44. She died a mere 7 months later, leaving a young son.

Dana Reeve's story shows that smoking cannot fully explain lung cancer. Everyone in this country could stop smoking today, and yet we would still face a lung cancer epidemic. According to the Lung Cancer Alliance, over 60 percent of new lung cancer cases occur in those who never smoked, or who quit smoking.

I believe that we have the expertise and technology to make serious progress against this deadly cancer, and to reach the goal of halving lung cancer mortality by 2015.

We need this legislation to ensure that our Government's resources are focused on this mission in the most efficient way possible.

Agency efforts must be coordinated, and every part of the National Institutes of Health that may have some ideas to lend should be participating. That is what the Lung Cancer Mortality Reduction Program will accomplish.

We can do better for Americans diagnosed with lung cancer. I ask my colleagues to support this legislation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 332

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Lung Cancer Mortality Reduction Act of 2009''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Lung cancer is the leading cause of cancer death for both men and women, accounting for 28 percent of all cancer deaths.

(2) Lung cancer kills more people annually than breast cancer, prostate cancer, colon cancer, liver cancer, melanoma, and kidney cancer combined.

(3) Since the enactment of the National Cancer Act of 1971 (Public Law 92–218; 85 Stat. 778), coordinated and comprehensive research has raised the 5-year survival rates for breast cancer to 88 percent, for prostate cancer to 99 percent, and for colon cancer to 64 percent.

(4) However, the 5-year survival rate for lung cancer is still only 15 percent and a similar coordinated and comprehensive research effort is required to achieve increases in lung cancer survivability rates.

(5) Sixty percent of lung cancer cases are now diagnosed as nonsmokers or former smokers.

(6) Two-thirds of nonsmokers diagnosed with lung cancer are women.

(7) Certain minority populations, such as African-American males, have disproportionately high rates of lung cancer incidence and mortality, notwithstanding their similar smoking rate.

(8) Members of the baby boomer generation are entering their sixties, the most common age at which people develop lung cancer.

(9) Tobacco addiction and exposure to other lung cancer carcinogens such as Agent Orange and other herbicides and battlefield emissions are serious problems among military personnel and war veterans.

(10) Significant and rapid improvements in lung cancer mortality can be expected through greater use and access to lung cancer screening tests for at-risk individuals.

(11) Additional strategies are necessary to further enhance the existing tests and therapies available to diagnose and treat lung cancer in the future.

(12) The August 2001 Report of the Lung Cancer Progress Review Group of the National Cancer Institute stated that funding for lung cancer research was ''far below the levels characterized for other common malignancies and far out of proportion to its massive health impact''.

(13) The Report of the Lung Cancer Progress Review Group identified as its ''highest priority'' the creation of integrated, multidisciplinary, multi-institutional research consortia organized around the problem of lung cancer.

(14) The United States must enhance its response to the issues raised in the Report of the Lung Cancer Progress Review Group, and this can be accomplished through the establishment of a coordinated effort designed to reduce the lung cancer mortality rate by 50 percent by 2016 and through targeted funding to support this coordinated effort.

SEC. 3. SENSE OF THE SENATE CONCERNING INVESTMENT IN LUNG CANCER RESEARCH.

It is the sense of the Senate that—

(1) lung cancer mortality reduction should be made a national public health priority; and

(2) a comprehensive mortality reduction program coordinated by the Secretary of Health and Human Services is justified and necessary to adequately address and reduce lung cancer mortality.

SEC. 4. LUNG CANCER MORTALITY REDUCTION PROGRAM.

(a) IN GENERAL.—Subpart 1 of part C of title IV of the Public Health Service Act (42 U.S.C. 285 et seq.) is amended by adding at the end the following:

''SEC. 417G. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of the Lung Cancer Mortality Reduction Act of 2009, the Secretary, in consultation with the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the National Institutes of

Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of the Food and Drug Administration, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Center on Minority Health and Health Disparities, and other members of the Lung Cancer Advisory Board established under section 6 of the Lung Cancer Mortality Reduction Act of 2009, shall implement a comprehensive program to achieve a 50 percent reduction in the mortality rate of lung cancer by 2016.

''(b) REQUIREMENTS.—The program implemented under subsection (a) shall include at least the following:

''(1) With respect to the National Institutes of Health—

''(A) a strategic review and prioritization by the National Cancer Institute of research grants to achieve the goal of the program in reducing lung cancer mortality;

''(B) the provision of funds to enable the Airway Biology and Disease Branch of the National Heart, Lung, and Blood Institute to expand its research programs to include predispositions to lung cancer, the interrelationship between lung cancer and other pulmonary and cardiac disease, and the diagnosis and treatment of these interrelationships;

''(C) the provision of funds to enable the National Institute of Biomedical Imaging and Bioengineering to expand its Quantum Grant Program and Image-Guided Interventions programs to expedite the development of computer assisted diagnostic, surgical, treatment, and drug testing innovations to reduce lung cancer mortality; and

''(D) the provision of funds to enable the National Institute of Environmental Health Sciences to implement research programs relative to lung cancer incidence.

''(2) With respect to the Food and Drug Administration—

''(A) the establishment of a lung cancer mortality reduction drug program under subchapter G of chapter V of the Federal Food, Drug, and Cosmetic Act; and

''(B) compassionate access activities under section 561 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb).

''(3) With respect to the Centers for Disease Control and Prevention, the establishment of a lung cancer mortality reduction program under section 1511.

''(4) With respect to the Agency for Healthcare Research and Quality, the conduct of a biannual review of lung cancer screening, diagnostic and treatment protocols, and the issuance of updated guidelines.

''(5) The cooperation and coordination of all minority and health disparity programs within the Department of Health and Human Services to ensure that all aspects of the Lung Cancer Mortality Reduction Program adequately address the burden of lung cancer on minority and rural populations.

''(6) The cooperation and coordination of all tobacco control and cessation programs within agencies of the Department of Health and Human Services to achieve the goals of the Lung Cancer Mortality Reduction Program with particular emphasis on the coordination of drug and other cessation treatments with early detection protocols.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

''(1) $25,000,000 for fiscal year 2010 for the activities described in subsection (b)(1)(B), and such sums as may be necessary for each of fiscal years 2011 through 2014;

''(2) $25,000,000 for fiscal year 2010 for the activities described in subsection (b)(1)(C), and such sums as may be necessary for each of fiscal years 2011 through 2014;

''(3) $10,000,000 for fiscal year 2010 for the activities described in subsection (b)(1)(D), and such sums as may be necessary for each of fiscal years 2011 through 2014; and

''(4) $15,000,000 for fiscal year 2010 for the activities described in subsection (b)(3), and such sums as may be necessary for each of fiscal years 2011 through 2014.''.

(b) FOOD, DRUG, AND COSMETIC ACT.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by adding at the end the following:

''Subchapter G—Lung Cancer Mortality Reduction Programs

''SEC. 581. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—The Secretary shall implement a program to provide incentives of the type provided for in subchapter B of this chapter for the development of chemoprevention drugs for precancerous conditions of the lung, drugs for targeted therapeutic treatments and vaccines for lung cancer, and new agents to curtail or prevent nicotine addiction. The Secretary shall model the program implemented under this section on the program provided for under subchapter B of this chapter with respect to certain drugs.

''(b) APPLICATION OF PROVISIONS.—The Secretary shall apply the provisions of subchapter B of this chapter to drugs, biological products, and devices for the prevention or treatment of lung cancer, including drugs, biological products, and devices for chemoprevention of precancerous conditions of the lungs, vaccination against the development of lung cancer, and therapeutic treatment for lung cancer.

''(c) BOARD.—The Board established under section 6 of the Lung Cancer Mortality Reduction Act of 2009 shall monitor the program implemented under this section.''.

(c) ACCESS TO UNAPPROVED THERAPIES.—Section 561(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb(e)) is amended by inserting before the period the following: ''and shall include providing compassionate access to drugs, biological products, and devices under the program under section 581, with substantial consideration being given to whether the totality of information available to the Secretary regarding the safety and effectiveness of an investigational drug, as compared to the risk of morbidity and death from the disease, indicates that a patient may obtain more benefit than risk if treated with the drug, biological product, or device.''.

(d) CDC.—Title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) is amended by adding at the end the following:

''SEC. 1511. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—The Secretary shall establish and implement an early disease research and management program targeted at the high incidence and mortality rates among minority and low-income populations.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this section.''.

SEC. 5. DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS.

The Secretary of Defense and the Secretary of Veterans Affairs shall coordinate with the Secretary of Health and Human Services—

(1) in the development of the Lung Cancer Mortality Reduction Program under section 417E of part C of title IV of the Public Health Service Act, as amended by section 4;

(2) in the implementation within the Department of Defense and the Department of Veterans Affairs of an early detection and disease management research program for military personnel and veterans whose smoking history and exposure to carcinogens during active duty service has increased their risk for lung cancer; and

(3) in the implementation of coordinated care programs for military personnel and veterans diagnosed with lung cancer.

SEC. 6. LUNG CANCER ADVISORY BOARD.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a Lung Cancer Advisory Board (referred to in this section as the ''Board'') to monitor the programs established under this Act (and the amendments made by this Act), and provide annual reports to Congress concerning benchmarks, expenditures, lung cancer statistics, and the public health impact of such programs.

(b) COMPOSITION.—The Board shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Defense;

(3) the Secretary of Veterans Affairs; and

(4) two representatives each from the fields of—

(A) clinical medicine focused on lung cancer;

(B) lung cancer research;

(C) imaging;

(D) drug development; and

(E) lung cancer advocacy,

to be appointed by the Secretary of Health and Human Services.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out the programs under this Act (and the amendments made by this Act), there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

By Mr. LUGAR:

S. 334. A bill to authorize the extension of nondiscriminatory treatment (normal trade relations treatment) to the products of Moldova; to the Committee on Finance.

Mr. LUGAR. Mr. President, I rise today to introduce legislation designed to extend permanent normal trade relations to Moldova. Moldova is still subject to the provisions of the Jackson-Vanik amendment to the Trade Act of 1974, which sanctions nations for failure to comply with freedom of emigration requirements. This bill would repeal permanently the application of Jackson-Vanik to Moldova.

Moldova is a small country located in Europe between Ukraine and Romania. Throughout the Cold War it was a part of the Soviet Union. It gained its independence from the Soviet Union on August 27, 1991. The United States has supported Moldova in its journey toward democracy and sovereignty.

The United States enjoys good relations with Moldova and has encouraged Moldovan efforts to integrate with Euro-Atlantic institutions. Moldova has been selected to participate in the Eastern Partnership, an initiative proposed by the European Union in 2008, which will facilitate the creation of free trade agreements, energy security plans, and closer economic ties between the EU and Moldova.

Since declaring independence from the Soviet Union in 1992, Moldova has enacted a series of democratic and free market reforms. In 2001, Moldova became a member of the World Trade Organization. Furthermore, Moldovan

President Vladimir Voronin has recently expressed his desire to sign an accord to strengthen relations between Moldova and the European Union this year. Until the United States terminates application of Jackson-Vanik on Moldova, the U.S. will not benefit from Moldova's market access commitments nor can it resort to WTO dispute resolution mechanisms. While all other WTO members currently enjoy these benefits, the U.S. does not.

The Republic of Moldova has been evaluated every year and granted normal trade relations with the United States through annual presidential waivers from the effects of Jackson-Vanik. The Moldovan constitution guarantees its citizens the right to emigrate and this right is respected in practice. Most emigration restrictions were eliminated in 1991 and virtually no problems with emigration have been reported in the 16 years since independence. More specifically, Moldova does not impose emigration restrictions on members of the Jewish community. Synagogues function openly and without harassment. As a result, the administration finds that Moldova is in full compliance with Jackson-Vanik's provisions.

Since declaring independence from the Soviet Union in 1992, Moldova has enacted a series of democratic and free market reforms. Parliamentary elections in 2005 and local elections in 2007 generally complied with international standards for democratic elections.

Moldova has also contributed constructively towards a resolution of the long-standing separatist conflict in the country's Transniestria region, most recently by proposing a series of confidence-building measures and working groups. In addition, trade increased between the two parties by 30 percent in 2007.

The United States and Moldova have established a strong record of achievement in security cooperation. In 1997 the Nunn-Lugar Cooperative Threat Reduction Program responded to a Moldovan request for assistance. The U.S. purchased and secured 14 nuclear-capable MiG–29Cs from Moldova. These fighter aircraft were built by the former Soviet Union to launch nuclear weapons. Moldova expressed concern that these aircraft were unsecure due to the lack of funds and equipment necessary to ensure they were not stolen or smuggled out of the country. Specifically, emissaries from Iran had shown great interest and had attempted to acquire the aircraft. These planes were not destroyed. They were disassembled and shipped to Wright Patterson Air Force Base because they can be used by American experts for research purposes.

Moldova has made small, but important, troop contributions in Iraq. These contributions include significant demining capabilities and contingents of combat troops. I am pleased that the United States remains prepared to assist in weapons and ammunition disposal and force relocation assistance to help deal with the costs of military realignments in Moldova and to assist with military downsizing and reforms.

One of the areas where we can deepen U.S.-Moldovan relations is bilateral trade. In light of its adherence to freedom of emigration requirements, compliance with threat reduction and cooperation in the global war on terrorism, the products of Moldova should not be subject to the sanctions of Jackson-Vanik. The U.S. must remain committed and engaged in assisting Moldova in pursuing economic and development reforms. The government in Chisinau still has important work to do in these critical areas. The support and encouragement of the U.S. and the international community will be key to encouraging the Government of Moldova to take the necessary steps to initiate reform. The permanent waiver of Jackson-Vanik and establishment of permanent normal trade relations will be the foundation on which further progress in a burgeoning economic and energy partnership can be made.

I am hopeful that my colleagues will join me in supporting this important legislation. It is essential that we act promptly to bolster this important relationship and promote stability in this region.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 22—RECOGNIZING THE GOALS OF CATHOLIC SCHOOLS WEEK AND HONORING THE VALUABLE CONTRIBUTIONS OF CATHOLIC SCHOOLS IN THE UNITED STATES

Mr. VITTER (for himself and Ms. LANDRIEU) submitted the following resolution; which was considered and agreed to:

S. RES. 22

Whereas Catholic schools in the United States have received international acclaim for academic excellence while providing students with lessons that extend far beyond the classroom;

Whereas Catholic schools present a broad curriculum that emphasizes the lifelong development of moral, intellectual, physical, and social values in the young people of the United States;

Whereas Catholic schools in the United States today educate 2,270,913 students and maintain a student-to-teacher ratio of 14 to 1;

Whereas the faculty members of Catholic schools teach a highly diverse body of students;

Whereas the graduation rate for all Catholic school students is 95 percent;

Whereas 83 percent of Catholic high school graduates go on to college;

Whereas Catholic schools produce students strongly dedicated to their faith, values, families, and communities by providing an intellectually stimulating environment rich in spiritual character and moral development; and

Whereas in the 1972 pastoral message concerning Catholic education, the National Conference of Catholic Bishops stated, ''Education is one of the most important ways by which the Church fulfills its commitment to the dignity of the person and building of community. Community is central to education ministry, both as a necessary condition and an ardently desired goal. The educational efforts of the Church, therefore, must be directed to forming persons-in-community; for the education of the individual Christian is important not only to his solitary destiny, but also the destinies of the many communities in which he lives.'': Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the goals of Catholic Schools Week, an event cosponsored by the National Catholic Educational Association and the United States Conference of Catholic Bishops that recognizes the vital contributions of thousands of Catholic elementary and secondary schools in the United States; and

(2) commends Catholic schools, students, parents, and teachers across the United States for their ongoing contributions to education, and for the vital role they play in promoting and ensuring a brighter, stronger future for the United States.

SENATE RESOLUTION 23—HONORING THE LIFE OF ANDREW WYETH

Mr. CASEY (for himself, Mr. SPECTER, Ms. SNOWE, and Ms. COLLINS) submitted the following resolution; which was considered and agreed to:

S. RES. 23

Whereas Andrew Wyeth was one of the most popular American artists of the twentieth century, whose paintings presented to the world his impressions of rural American landscapes and lives;

Whereas Andrew Wyeth was born in Chadds Ford, Pennsylvania on July 12, 1917, where he spent much of his life and where today stands the Brandywine River Museum, a museum dedicated to the works of the Wyeth family;

Whereas Andrew Wyeth died the morning of January 16, 2009, at the age of 91, in his home in Chadds Ford, Pennsylvania;

Whereas it is the intent of the Senate to recognize and pay tribute to the life of Andrew Wyeth, his passion for painting, his contribution to the world of art, and his deep understanding of the human condition;

Whereas Andrew Wyeth was born the son of famed illustrator N.C. Wyeth and grew up surrounded by artists in an environment that encouraged imagination and free-thinking;

Whereas Andrew Wyeth became an icon who focused his work on family and friends in Chadds Ford and in coastal Maine, where he spent his summers and where he met Christina Olson, the subject of his famed painting 'Christina's World';

Whereas Andrew Wyeth's paintings were immensely popular among the public but sometimes disparaged by critics for their lack of color and bleak landscapes portraying isolation and alienation;

Whereas Andrew Wyeth's works could be controversial, as they sparked dialogue and disagreement in the art world concerning the natures of realism and modernism;

Whereas Andrew Wyeth was immensely patriotic and an independent thinker who broke with many of his peers on the issues of the day;

Whereas Andrew Wyeth was a beloved figure in Chadds Ford and had his own seat at the corner table of the Chadds Ford Inn, where reproductions of his art line the walls;

Whereas Andrew Wyeth received the Presidential Medal of Freedom in 1963 and the Congressional Gold Medal of Honor in 1988;

Whereas Andrew Wyeth let it be known that he lived to paint and never lost his simplicity and caring for people despite his immense fame and successful career; and

Whereas the passing of Andrew Wyeth is a great loss to the world of art, and his life should be honored with highest praise and appreciation for his paintings which remain with us although he is gone: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes Andrew Wyeth as a treasure of the United States and one of the most popular artists of the twentieth century; and

(2) recognizes the outstanding contributions of Andrew Wyeth to the art world and to the community of Chadds Ford, Pennsylvania.

AMENDMENTS SUBMITTED AND PROPOSED

SA 39. Mr. REID (for Mr. BAUCUS) proposed an amendment to 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.

SA 40. Mr. MCCONNELL (for himself, Mr. KYL, Mr. VITTER, Mr. CHAMBLISS, Mr. BUNNING, Mr. GREGG, Mr. COBURN, Mr. BURR, Mr. ISAKSON, Mr. GRAHAM, Mr. INHOFE, Mr. CORNYN, Mr. BROWNBACK, Mr. COCHRAN, Mr. ENSIGN, Mr. THUNE, Mr. DEMINT, Mr. BENNETT, Mr. BARRASSO, Mr. ENZI, and Mr. WICKER) submitted an amendment intended to be proposed by him to the bill H.R. 2, supra.

SA 41. Mr. GRASSLEY (for himself, Mr. HATCH, Mr. ROBERTS, Mr. VITTER, and Mr. CHAMBLISS) submitted an amendment intended to be proposed by him to the bill H.R. 2, supra.

SA 42. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 43. Mr. DEMINT submitted an amendment intended to be proposed to amendment SA 39 proposed by Mr. REID (for Mr. BAUCUS) to the bill H.R. 2, supra.

SA 44. Mr. DEMINT (for himself and Mr. VITTER) submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 45. Mr. HATCH (for himself, Mr. GRASSLEY, and Mr. WICKER) proposed an amendment to amendment SA 39 proposed by Mr. REID (for Mr. BAUCUS) to the bill H.R. 2, supra.

SA 46. Mr. KYL submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 47. Mr. COBURN (for himself and Mr. THUNE) submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 48. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 49. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 50. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 51. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 52. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 53. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 54. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 55. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 56. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 57. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 58. Mr. WEBB (for himself, Mrs. HAGAN, and Mr. SANDERS) submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 59. Mr. VITTER submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 60. Mr. WICKER (for himself and Mr. COCHRAN) submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 61. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 62. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 63. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 64. Mr. BINGAMAN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 65. Mr. MARTINEZ (for himself, Mr. VITTER, Mr. WICKER, Mr. BUNNING, Mr. ENZI, Mr. COBURN, Mr. JOHANNS, Mr. BROWNBACK, Mr. INHOFE, Mr. CHAMBLISS, and Mr. DEMINT) submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 66. Mr. CORNYN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 67. Mr. CORNYN submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 68. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 69. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 70. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 71. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 72. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

SA 73. Mr. GRASSLEY submitted an amendment intended to be proposed by him to the bill H.R. 2, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 39. Mr. REID (for Mr. BAUCUS) proposed an amendment to 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; as follows:

Strike all after the enacting clause and insert the following:

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

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

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

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

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

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

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

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

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

TITLE I—FINANCING

Subtitle A—Funding

Sec. 101. Extension of CHIP.
Sec. 102. Allotments for States and territories for fiscal years 2009 through 2013.
Sec. 103. Child Enrollment Contingency Fund.
Sec. 104. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts.
Sec. 105. Two-year initial availability of CHIP allotments.
Sec. 106. Redistribution of unused allotments.
Sec. 107. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.
Sec. 108. One-time appropriation.
Sec. 109. Improving funding for the territories under CHIP and Medicaid.

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

Sec. 111. State option to cover low-income pregnant women under CHIP through a State plan amendment.
Sec. 112. Phase-out of coverage for nonpregnant childless adults under CHIP; conditions for coverage of parents.
Sec. 113. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment.

Sec. 114. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line.
Sec. 115. State authority under Medicaid.
TITLE II—OUTREACH AND ENROLLMENT
Subtitle A—Outreach and Enrollment Activities
Sec. 201. Grants and enhanced administrative funding for outreach and enrollment.
Sec. 202. Increased outreach and enrollment of Indians.
Sec. 203. State option to rely on findings from an Express Lane agency to conduct simplified eligibility determinations.
Subtitle B—Reducing Barriers to Enrollment
Sec. 211. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.
Sec. 212. Reducing administrative barriers to enrollment.
Sec. 213. Model of Interstate coordinated enrollment and coverage process.
Sec. 214. Permitting States to ensure coverage without a 5-year delay of certain children and pregnant women under the Medicaid program and CHIP.
TITLE III—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE
Subtitle A—Additional State Option for Providing Premium Assistance
Sec. 301. Additional State option for providing premium assistance.
Sec. 302. Outreach, education, and enrollment assistance.
Subtitle B—Coordinating Premium Assistance With Private Coverage
Sec. 311. Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of coverage.
TITLE IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES
Sec. 401. Child health quality improvement activities for children enrolled in Medicaid or CHIP.
Sec. 402. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.
Sec. 403. Application of certain managed care quality safeguards to CHIP.
TITLE V—IMPROVING ACCESS TO BENEFITS
Sec. 501. Dental benefits.
Sec. 502. Mental health parity in CHIP plans.
Sec. 503. Application of prospective payment system for services provided by Federally-qualified health centers and rural health clinics.
Sec. 504. Premium grace period.
Sec. 505. Clarification of coverage of services provided through school-based health centers.
Sec. 506. Medicaid and CHIP Payment and Access Commission.
TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS
Subtitle A—Program Integrity and Data Collection
Sec. 601. Payment error rate measurement (''PERM'').
Sec. 602. Improving data collection.
Sec. 603. Updated Federal evaluation of CHIP.
Sec. 604. Access to records for IG and GAO audits and evaluations.
Sec. 605. No Federal funding for illegal aliens; disallowance for unauthorized expenditures.
Subtitle B—Miscellaneous Health Provisions
Sec. 611. Deficit Reduction Act technical corrections.
Sec. 612. References to title XXI.
Sec. 613. Prohibiting initiation of new health opportunity account demonstration programs.
Sec. 614. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.
Sec. 615. Clarification treatment of regional medical center.
Sec. 616. Extension of Medicaid DSH allotments for Tennessee and Hawaii.
Sec. 617. GAO report on Medicaid managed care payment rates.
Subtitle C—Other Provisions
Sec. 621. Outreach regarding health insurance options available to children.
Sec. 622. Sense of the Senate regarding access to affordable and meaningful health insurance coverage.
TITLE VII—REVENUE PROVISIONS
Sec. 701. Increase in excise tax rate on tobacco products.
Sec. 702. Administrative improvements.
Sec. 703. Treasury study concerning magnitude of tobacco smuggling in the United States.
Sec. 704. Time for payment of corporate estimated taxes.

SEC. 2. PURPOSE.

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

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

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

(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet one or more additional requirements imposed by amendments made by this Act, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

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

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

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

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

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

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

TITLE I—FINANCING

Subtitle A—Funding

SEC. 101. EXTENSION OF CHIP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(1) FOR FISCAL YEAR 2009.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(3) FOR FISCAL YEAR 2013.—

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

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

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

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

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

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

''(i) the sum of—

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

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

''(ii) the sum of the—

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 103. CHILD ENROLLMENT CONTINGENCY FUND.

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

''(n) CHILD ENROLLMENT CONTINGENCY FUND.—

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

''(2) DEPOSITS INTO FUND.—

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

''(i) for fiscal year 2009, an amount equal to 20 percent of the amount made available under paragraph (12) of subsection (a) for the fiscal year; and

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

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

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

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

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

''(A) IN GENERAL.—If a State's expenditures under this title in fiscal year 2009, fiscal year 2010, fiscal year 2011, fiscal year 2012, or a semi-annual allotment period for fiscal year 2013, exceed the total amount of allotments available under this section to the State in the fiscal year or period (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year or period, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year or period exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year or period, subject to subparagraph (D), the Secretary shall pay to the State from the Fund an amount equal to the product of—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(D) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—For purposes of subparagraph (B), the projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average

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

''(E) AMOUNTS AVAILABLE FOR PAYMENTS.—

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

''(ii) TRANSFERS.—Notwithstanding any other provision of this title, the following amounts shall also be available, without fiscal year limitation, for making payments under this paragraph:

''(I) UNOBLIGATED NATIONAL ALLOTMENT.—

''(aa) FISCAL YEARS 2009 THROUGH 2012.—As of December 31 of fiscal year 2009, and as of December 31 of each succeeding fiscal year through fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.

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

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

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

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

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

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

''(F) QUALIFYING CHILDREN DEFINED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

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

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

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

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

the fiscal year in which they are redistributed.''.

SEC. 106. REDISTRIBUTION OF UNUSED ALLOTMENTS.

(a) BEGINNING WITH FISCAL YEAR 2007.—

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

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

''(1) IN GENERAL.—The Secretary'';

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

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

''(2) SHORTFALL STATES DESCRIBED.—

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

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

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

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

''(B) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally.

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

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

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

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

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

(3) in paragraph (6)—

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

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

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

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

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

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

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

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

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

''(A) PAYMENT OF ENHANCED PORTION OF MATCHING RATE FOR CERTAIN EXPENDITURES.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 2104 for any of fiscal years 2009 through 2013 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

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

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

SEC. 108. ONE-TIME APPROPRIATION.

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

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

Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

''(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal years beginning with fiscal year 2009, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), and (3) of this subsection) to such commonwealth or territory for such fiscal year.''.

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

SEC. 111. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN UNDER CHIP THROUGH A STATE PLAN AMENDMENT.

(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 112(a), is amended by adding at the end the following new section:

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

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

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

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

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

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

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

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

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

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

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

''(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the

enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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

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

''(1) PREGNANCY-RELATED ASSISTANCE.—The term 'pregnancy-related assistance' has the meaning given the term 'child health assistance' in section 2110(a) with respect to an individual during the period described in paragraph (2)(A).

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

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

''(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

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

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

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

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

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

''(B) pregnancy-related services through the application of any waiver authority (as in effect on June 1, 2008).

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

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

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

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

(b) ADDITIONAL CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

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

SEC. 112. PHASE-OUT OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS UNDER CHIP; CONDITIONS FOR COVERAGE OF PARENTS.

(a) PHASE-OUT RULES.—

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

''SEC. 2111. PHASE-OUT OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS; CONDITIONS FOR COVERAGE OF PARENTS.

''(a) TERMINATION OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

''(1) NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH 2009.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

''(A) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2009, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

''(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraph (2) shall apply for purposes of any period beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

''(2) TERMINATION OF CHIP COVERAGE UNDER APPLICABLE EXISTING WAIVERS AT THE END OF 2009.—

''(A) IN GENERAL.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after December 31, 2009.

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

''(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during the period beginning on the date of the enactment of this subsection and ending on December 31, 2009.

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

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

''(B) DEADLINE FOR APPROVAL.—The Secretary shall make a decision to approve or deny an application for a Medicaid nonpregnant childless adults waiver submitted under subparagraph (A) within 90 days of the date of the submission of the application. If no decision has been made by the Secretary as of December 31, 2009, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by September 30, 2009, the application shall be deemed approved.

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

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

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

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

''(1) TWO-YEAR PERIOD; AUTOMATIC EXTENSION AT STATE OPTION THROUGH FISCAL YEAR 2011.—

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

''(i) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a parent of a targeted low-income child; and

''(ii) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2011, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

''(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2011, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only, subject to paragraph (2)(A), through September 30, 2011.

''(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a parent of a targeted low-income child during the third and fourth quarters of fiscal year 2009 and during fiscal years 2010 and 2011.

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

''(A) PAYMENTS FOR COVERAGE LIMITED TO BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Any State that provides child health assistance or health benefits coverage under an applicable existing waiver for a parent of a targeted low-income child may elect to continue to provide such assistance or coverage through fiscal year 2012 or 2013, subject to the same terms and conditions that applied under the applicable existing waiver, unless otherwise modified in subparagraph (B).

''(B) TERMS AND CONDITIONS.—

''(i) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—If the State makes an election under subparagraph (A), the Secretary shall set aside for the State for each such fiscal year an amount equal to the Federal share of 110 percent of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all parents of targeted low-income children enrolled under such waiver for the fiscal year (as certified by the State and submitted to the Secretary by not later than August 31 of the preceding fiscal year). In the case of fiscal year 2013, the set aside for any State shall be computed separately for each period described in subparagraphs (A) and (B) of section 2104(a)(16) and any reduction in the allotment for either such period under section 2104(m)(4) shall be allocated on a pro rata basis to such set aside.

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

''(iii) ENHANCED FMAP ONLY IN FISCAL YEAR 2012 FOR STATES WITH SIGNIFICANT CHILD OUTREACH OR THAT ACHIEVE CHILD COVERAGE BENCHMARKS; FMAP FOR ANY OTHER STATES.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2012 is equal to—

''(I) the enhanced FMAP determined under section 2105(b) in the case of a State that meets the outreach or coverage benchmarks described in any of subparagraph (A), (B), or (C) of paragraph (3) for fiscal year 2011; or

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

''(iv) AMOUNT OF FEDERAL MATCHING PAYMENT IN 2013.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2013 is equal to—

''(I) the REMAP percentage if—

''(aa) the applicable percentage for the State under clause (iii) was the enhanced FMAP for fiscal year 2012; and

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

''(II) the Federal medical assistance percentage (as so determined) in the case of any State to which subclause (I) does not apply. For purposes of subclause (I), the REMAP percentage is the percentage which is the sum of such Federal medical assistance percentage and a number of percentage points equal to one-half of the difference between such Federal medical assistance percentage and such enhanced FMAP.

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

''(vi) NO INCREASE IN INCOME ELIGIBILITY LEVEL FOR PARENTS.—No payments shall be made to a State from the amount set aside under clause (i) for a fiscal year for expenditures for providing child health assistance or health benefits coverage to a parent of a targeted low-income child whose family income exceeds the income eligibility level applied under the applicable existing waiver to parents of targeted low-income children on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009.

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

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

''(i) was awarded a grant under section 2113 for fiscal year 2011;

''(ii) implemented 1 or more of the enrollment and retention provisions described in section 2105(a)(4) for such fiscal year; or

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

''(B) HIGH-PERFORMING STATE.—The State, on the basis of the most timely and accurate published estimates of the Bureau of the Census, ranks in the lowest ⅓ of States in terms of the State's percentage of low-income children without health insurance.

''(C) STATE INCREASING ENROLLMENT OF LOW-INCOME CHILDREN.—The State qualified for a performance bonus payment under section 2105(a)(3)(B) for the most recent fiscal year applicable under such section.

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

''(c) APPLICABLE EXISTING WAIVER.—For purposes of this section—

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

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

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

''(ii) a nonpregnant childless adult; or

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

''(B) was in effect during fiscal year 2009.

''(2) DEFINITIONS.—

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

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

(2) CONFORMING AMENDMENTS.—

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

(i) by striking '', the Secretary'' and inserting '':

''(1) The Secretary'';

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

(iii) by striking the second sentence; and

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

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009 that would waive or modify the requirements of section 2111.''.

(B) Section 6102(c) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 131) is amended by striking ''Nothing'' and inserting ''Subject to section 2111 of the Social Security Act, as added by section 112 of the Children's Health Insurance Program Reauthorization Act of 2009, nothing''.

(b) GAO STUDY AND REPORT.—

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

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

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

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall report the results of the study to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives, including recommendations (if any) for changes in legislation.

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

(a) IN GENERAL.—Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''(or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))''; and

(2) by striking subparagraph (B) and inserting the following new subparagraph:

''(B) [reserved]''.

(b) AMENDMENTS TO MEDICAID.—

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

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

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

SEC. 114. LIMITATION ON MATCHING RATE FOR STATES THAT PROPOSE TO COVER CHILDREN WITH EFFECTIVE FAMILY INCOME THAT EXCEEDS 300 PERCENT OF THE POVERTY LINE.

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

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

''(A) FMAP APPLIED TO EXPENDITURES.—Except as provided in subparagraph (B), for fiscal years beginning with fiscal year 2009, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to any State that, on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in such subparagraph under the State child health plan.''.

(b) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as—

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

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

SEC. 115. STATE AUTHORITY UNDER MEDICAID.

Notwithstanding any other provision of law, including the fourth sentence of subsection (b) of section 1905 of the Social Security Act (42 U.S.C. 1396d) or subsection (u) of such section, at State option, the Secretary shall provide the State with the Federal medical assistance percentage determined for the State for Medicaid with respect to expenditures described in section 1905(u)(2)(A) of such Act or otherwise made to provide medical assistance under Medicaid to a child who could be covered by the State under CHIP.

TITLE II—OUTREACH AND ENROLLMENT

Subtitle A—Outreach and Enrollment Activities

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

(a) GRANTS.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 111, is amended by adding at the end the following:

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

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

''(1) IN GENERAL.—From the amounts appropriated under subsection (g), subject to paragraph (2), the Secretary shall award grants to eligible entities during the period of fiscal years 2009 through 2013 to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

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

''(b) PRIORITY FOR AWARD OF GRANTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(f) DEFINITIONS.—In this section:

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

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

''(B) A local government.

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

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

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

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

''(G) An elementary or secondary school.

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

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

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

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

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

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

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

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

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

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

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

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

''(F) by providing referral and followup services.

''(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $100,000,000 for the period of fiscal years 2009 through 2013, for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

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

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

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

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

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

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

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

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

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

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

(B) in subparagraph (D)—

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

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

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

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

(2) MEDICAID.—

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

''(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment of, retention of, and use of services under this title by, children of families for whom English is not the primary language; plus''.

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

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

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

SEC. 202. INCREASED OUTREACH AND ENROLLMENT OF INDIANS.

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

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

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

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

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

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

''(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms 'Indian', 'Indian Tribe', 'Indian Health Program', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

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

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

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

SEC. 203. STATE OPTION TO RELY ON FINDINGS FROM AN EXPRESS LANE AGENCY TO CONDUCT SIMPLIFIED ELIGIBILITY DETERMINATIONS.

(a) APPLICATION UNDER MEDICAID AND CHIP PROGRAMS.—

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

''(13) EXPRESS LANE OPTION.—

''(A) IN GENERAL.—

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

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

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

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

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

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

''(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the

provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

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

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

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

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

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

''(ii) ESTABLISHING A SCREENING THRESHOLD.—

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

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

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

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

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

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

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

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

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

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

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

''(D) OPTION FOR AUTOMATIC ENROLLMENT.—

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

''(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

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

''(i) IN GENERAL.—For purposes of subparagraph (A)(iv), the requirement of this subparagraph for a State is that the State agrees to—

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

''(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

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

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

''(V) if such error rate exceeds 3 percent for any fiscal year in which the State elects to apply this paragraph, a reduction in the amount otherwise payable to the State under section 1903(a) for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

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

''(iii) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under section 1903(u), for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

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

''(F) EXPRESS LANE AGENCY.—

''(i) IN GENERAL.—In this paragraph, the term 'Express Lane agency' means a public agency that—

''(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of one or more eligibility requirements described in subparagraph (A)(i);

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

''(III) notifies the child's family—

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

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

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

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

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

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

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

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

''(cc) The State Medicaid plan.

''(dd) The State CHIP plan.

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

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

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

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

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

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

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

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

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

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

''(iii) EXCLUSIONS.—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX or a private, for-profit organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) EVALUATION AND REPORT.—

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

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

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

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

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

(2) REPORT TO CONGRESS.—Not later than September 30, 2012, the Secretary shall submit a report to Congress on the results of the evaluation under paragraph (1).

(3) FUNDING.—

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

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

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

''(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.''.

(d) AUTHORIZATION OF INFORMATION DISCLOSURE.—

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

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

''(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data directly relevant to eligibility determinations under this title (including eligibility files maintained by Express Lane agencies described in section 1902(e)(13)(F), information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, to the extent such conveyance meets the requirements of subsection (b).

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

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

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

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

''(B) verifying the eligibility of individuals for medical assistance under the State plan.

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

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

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

''(c) PENALTIES FOR IMPROPER DISCLOSURE.—

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

''(2) CRIMINAL PENALTY.—A private entity described in the subsection (a) that willfully publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section shall be fined not more than $10,000 or imprisoned not more than 1 year, or both, for each such unauthorized publication or disclosure.

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

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

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

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

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

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

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

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

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

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

Subtitle B—Reducing Barriers to Enrollment

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

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

(1) ALTERNATIVE TO DOCUMENTATION REQUIREMENT.—

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

(i) in subsection (a)(46)—

(I) by inserting ''(A)'' after ''(46)'';

(II) by adding ''and'' after the semicolon; and

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

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

''(i) section 1903(x); or

''(ii) subsection (ee);''; and

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

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

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

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

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

''(ii) in the case such inconsistency is not resolved under clause (i), the State—

''(I) notifies the individual of such fact;

''(II) provides the individual with a period of 90 days from the date on which the notice required under subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) or resolve the inconsistency with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); and

''(III) disenrolls the individual from the State plan under this title within 30 days after the end of such 90-day period if no such documentary evidence is presented or if such inconsistency is not resolved.

''(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1902(a)(46)(B) shall establish a program under which the State submits at least monthly to the Commissioner of Social Security for comparison of the name and social security number, of each individual newly enrolled in the State plan under this title that month who is not described in section 1903(x)(2) and who declares to be a United States citizen or national, with information in records maintained by the Commissioner.

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

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

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

''(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

''(3)(A) The State agency implementing the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the inconsistent submissions bears to the total submissions made for comparison for such month. For purposes of this subparagraph, a name, social security number, or declaration of citizenship or nationality of an individual shall be treated as inconsistent and included in the determination of such percentage only if—

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

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

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

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

''(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 percent—

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

''(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent information.

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

''(D) Subparagraphs (A) and (B) shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year that provides for the submission on a real-time basis of the information described in such paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B)(i), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.''.

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

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

(i) in paragraph (2)—

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

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

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

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

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

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

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

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

(A) in subparagraph (B)—

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

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

(B) in subparagraph (C)—

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

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

(c) APPLICATION OF DOCUMENTATION SYSTEM TO CHIP.—

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

''(9) CITIZENSHIP DOCUMENTATION REQUIREMENTS.—

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

''(B) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures described in clause (i) or (ii) of section 1903(a)(3)(F) necessary to comply with subparagraph (A) shall in no event be less than 90 percent and 75 percent, respectively.''.

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

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

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—

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

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

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

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

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on October 1, 2009, was determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by subsection (b), had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

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

SEC. 212. REDUCING ADMINISTRATIVE BARRIERS TO ENROLLMENT.

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

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

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

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

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

''(B) DEEMED COMPLIANCE IF JOINT APPLICATION AND RENEWAL PROCESS THAT PERMITS APPLICATION OTHER THAN IN PERSON.—A State shall be deemed to comply with subparagraph (A) if the State's application and renewal forms and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children and pregnant women for medical assistance under title XIX and child health assistance under this title, and such process does not require an application to be made in person or a face-to-face interview.''.

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

(a) IN GENERAL.—In order to assure continuity of coverage of low-income children under the Medicaid program and the State Children's Health Insurance Program (CHIP), not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with State Medicaid and CHIP directors and organizations representing program beneficiaries, shall develop a model process for the coordination of the enrollment, retention, and coverage under such programs of

children who, because of migration of families, emergency evacuations, natural or other disasters, public health emergencies, educational needs, or otherwise, frequently change their State of residency or otherwise are temporarily located outside of the State of their residency.

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

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

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

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

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

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

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

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

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

''(C) A State shall demonstrate that the State requires an individual provided medical assistance as a result of an election by the State under subparagraph (A), to provide the State, as part of the State's ongoing eligibility redetermination requirements and procedures, with documentation or other evidence that the individual is lawfully residing in the United States.''.

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

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

TITLE III—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

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

(a) CHIP.—

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

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

''(A) IN GENERAL.—A State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer-sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph. No subsidy shall be provided to a targeted low-income child under this paragraph unless the child (or the child's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of child health assistance.

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

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

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

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

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

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

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

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

''(C) PREMIUM ASSISTANCE SUBSIDY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

subsidy under this paragraph for enrollment in coverage made available through such pool.

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

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

''(J) NO EFFECT ON PREMIUM ASSISTANCE WAIVER PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906 or 1906A, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect prior to the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009.

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

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

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

''(iii) establish such other procedures as the State determines necessary to ensure that parents are fully informed of the choices for receiving child health assistance under the State child health plan or through the receipt of premium assistance subsidies.

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

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

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

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

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

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

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

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

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

''PREMIUM ASSISTANCE OPTION FOR CHILDREN

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

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

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

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

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

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

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

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

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

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

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

''(d) VOLUNTARY PARTICIPATION.—

''(1) EMPLOYERS.—Participation by an employer in a premium assistance subsidy offered by a State under this section shall be voluntary. An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee.

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

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

''(e) REQUIREMENT TO PAY PREMIUMS AND COST-SHARING AND PROVIDE SUPPLEMENTAL COVERAGE.—In the case of the participation of an individual under age 19 (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916 or, if applicable, section 1916A). The fact that an individual under age 19 (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as section 1902(a)(25) provides that payments for such assistance shall first be made under such coverage.''.

(c) GAO STUDY AND REPORT.—Not later than January 1, 2010, the Comptroller General of the United States shall study cost and coverage issues relating to any State premium assistance programs for which Federal matching payments are made under title XIX or XXI of the Social Security Act, including under waiver authority, and shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives on the results of such study.

SEC. 302. OUTREACH, EDUCATION, AND ENROLLMENT ASSISTANCE.

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

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

(b) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 211(c)(2), is amended by adding at the end the following new clause:

''(iii) EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF CHILDREN UNDER THIS TITLE AND TITLE xix THROUGH PREMIUM ASSISTANCE SUBSIDIES.—Expenditures for outreach activities to families of children likely to be eligible for premium assistance subsidies in accordance with paragraph (2)(B), (3), or (10), or a waiver approved under section 1115, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and to employers likely to provide qualified employer-sponsored coverage (as defined in subparagraph (B) of such paragraph), but not to exceed an amount equal to 1.25 percent of the maximum amount permitted to be expended under subparagraph (A) for items described in subsection (a)(1)(D).''.

Subtitle B—Coordinating Premium Assistance With Private Coverage

SEC. 311. SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF TERMINATION OF MEDICAID OR CHIP COVERAGE OR ELIGIBILITY FOR ASSISTANCE IN PURCHASE OF EMPLOYMENT-BASED COVERAGE; COORDINATION OF COVERAGE.

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

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

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

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

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

''(B) EMPLOYEE OUTREACH AND DISCLOSURE.—

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

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

''(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024).

''(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.''.

(b) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

''(B) COORDINATION WITH MEDICAID AND CHIP.—

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

''(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents.

''(II) MODEL NOTICE.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary and the Secretary of Health and Human Services, in consultation with Directors of State Medicaid agencies under title XIX of the Social Security Act and Directors of State CHIP agencies under title XXI of such Act, shall jointly develop national and State-specific model notices for purposes of subparagraph (A). The Secretary shall provide employers with such model notices so as to enable employers to timely comply with the requirements of subparagraph (A). Such model notices shall include information regarding how an employee may contact the State in which the employee resides for additional information regarding potential opportunities for such premium assistance, including how to apply for such assistance.

''(III) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b).

''(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through

premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.''.

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

(i) by striking ''and the remedies'' and inserting '', the remedies''; and

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

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

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

(I) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services and the Secretary of Labor shall jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group (in this subparagraph referred to as the ''Working Group''). The purpose of the Working Group shall be to develop the model coverage coordination disclosure form described in subclause (II) and to identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

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

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

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

(cc) The benefits offered under the plan.

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

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

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

(I) the Department of Labor;

(II) the Department of Health and Human Services;

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

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

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

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

(VII) health insurance issuers; and

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

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

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

(v) REPORT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(B) COORDINATION WITH MEDICAID AND CHIP.—

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

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

''(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974.

''(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of an enrollee in a group health plan who is covered

under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.''.

TITLE IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

SEC. 401. CHILD HEALTH QUALITY IMPROVEMENT ACTIVITIES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.

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

''SEC. 1139A. CHILD HEALTH QUALITY MEASURES.

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

''(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

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

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

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

''(B) The availability and effectiveness of a full range of—

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

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

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

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

''(4) ENCOURAGE VOLUNTARY AND STANDARDIZED REPORTING.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under titles XIX and XXI.

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

''(6) REPORTS TO CONGRESS.—Not later than January 1, 2011, and every 3 years thereafter, the Secretary shall report to Congress on—

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

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

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

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

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

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

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

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

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

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

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

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

''(1) ESTABLISHMENT OF PEDIATRIC QUALITY MEASURES PROGRAM.—Not later than January 1, 2011, the Secretary shall establish a pediatric quality measures program to—

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

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

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

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

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

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

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

''(D) periodically updated; and

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

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

''(A) States;

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

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

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

''(E) national organizations representing children, including children with disabilities and children with chronic conditions;

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

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

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

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

''(A) award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services

across the domains of quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A); and

''(B) award grants and contracts for—

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

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

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

''(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning no later than January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection paragraphs (1) through (4).

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

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

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

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

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

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

''(2) PUBLICATION.—Not later than September 30, 2010, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

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

''(1) IN GENERAL.—During the period of fiscal years 2009 through 2013, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under title XIX or XXI, including projects to—

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

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

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

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

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

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

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

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

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

''(e) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—

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

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

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

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

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

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

''(A) A city, county, or Indian tribe.

''(B) A local or tribal educational agency.

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

''(D) A Federally-qualified health center.

''(E) A local health department.

''(F) A health care provider.

''(G) A community-based organization.

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

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

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

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

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

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

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

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

''(I) after hours physical activity programs; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and

that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;

''(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;

''(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;

''(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;

''(E) located in communities that are medically underserved, as determined by the Secretary;

''(F) located in areas in which the average poverty rate is at least 150 percent or higher of the average poverty rate in the State involved, as determined by the Secretary; and

''(G) that submit plans that exhibit multisectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

''(i) community-based organizations;

''(ii) local governments;

''(iii) local educational agencies;

''(iv) the private sector;

''(v) State or local departments of health;

''(vi) accredited colleges, universities, and community colleges;

''(vii) health care providers;

''(viii) State and local departments of transportation and city planning; and

''(ix) other entities determined appropriate by the Secretary.

''(5) PROGRAM DESIGN.—

''(A) INITIAL DESIGN.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

''(B) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under title XXI in order to reduce the incidence of childhood obesity among such population.

''(6) REPORT TO CONGRESS.—Not later than 3 years after the date the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

''(7) DEFINITIONS.—In this subsection:

''(A) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given that term in section 1905(l)(2)(B).

''(B) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given that term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(C) SELF-ASSESSMENT.—The term 'self-assessment' means a form that—

''(i) includes questions regarding—

''(I) behavioral risk factors;

''(II) needed preventive and screening services; and

''(III) target individuals' preferences for receiving follow-up information;

''(ii) is assessed using such computer generated assessment programs; and

''(iii) allows for the provision of such ongoing support to the individual as the Secretary determines appropriate.

''(D) ONGOING SUPPORT.—The term 'ongoing support' means—

''(i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—

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

''(II) behavior modification based on the self-assessment; and

''(III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;

''(ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and

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

''(8) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2009 through 2013.

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

''(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or the State child health plan under title XXI that is—

''(A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;

''(B) designed to allow interoperable exchanges that conform with Federal and State privacy and security requirements;

''(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and

''(D) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records.

''(2) FUNDING.—$5,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

''(g) STUDY OF PEDIATRIC HEALTH AND HEALTH CARE QUALITY MEASURES.—

''(1) IN GENERAL.—Not later than July 1, 2010, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

''(A) consider all of the major national population-based reporting systems sponsored by the Federal Government that are currently in place, including reporting requirements under Federal grant programs and national population surveys and estimates conducted directly by the Federal Government;

''(B) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information so generated is made widely available through publication;

''(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

''(D) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality.

''(2) FUNDING.—Up to $1,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

''(h) RULE OF CONSTRUCTION.—Notwithstanding any other provision in this section, no evidence based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance under title XIX or child health assistance under title XXI.

''(i) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2009 through 2013, $45,000,000 for the purpose of carrying out this section (other than subsection (e)). Funds appropriated under this subsection shall remain available until expended.''.

(b) INCREASED MATCHING RATE FOR COLLECTING AND REPORTING ON CHILD HEALTH MEASURES.—Section 1903(a)(3)(A) (42 U.S.C. 1396b(a)(3)(A)), is amended—

(1) by striking ''and'' at the end of clause (i); and

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

''(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and''.

SEC. 402. IMPROVED AVAILABILITY OF PUBLIC INFORMATION REGARDING ENROLLMENT OF CHILDREN IN CHIP AND MEDICAID.

(a) INCLUSION OF PROCESS AND ACCESS MEASURES IN ANNUAL STATE REPORTS.—Section 2108 (42 U.S.C. 1397hh) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''The State'' and inserting ''Subject to subsection (e), the State''; and

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

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

''(1) Eligibility criteria, enrollment, and retention data (including data with respect

to continuity of coverage or duration of benefits).

''(2) Data regarding the extent to which the State uses process measures with respect to determining the eligibility of children under the State child health plan, including measures such as 12-month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility.

''(3) Data regarding denials of eligibility and redeterminations of eligibility.

''(4) Data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

''(5) If the State provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for child health assistance under the State child health plan, the range of the monthly amount of such assistance provided on behalf of a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the State child health plan to supplement the coverage purchased with such premium assistance, the effective strategies the State engages in to reduce any administrative barriers to the provision of such assistance, and, the effects, if any, of the provision of such assistance on preventing the coverage provided under the State child health plan from substituting for coverage provided under employer-sponsored health insurance offered in the State.

''(6) To the extent applicable, a description of any State activities that are designed to reduce the number of uncovered children in the State, including through a State health insurance connector program or support for innovative private health coverage initiatives.''.

(b) STANDARDIZED REPORTING FORMAT.—

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

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

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

(1) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $5,000,000 to the Secretary for fiscal year 2009 for the purpose of improving the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) for purposes of providing more timely data on enrollment and eligibility of children under Medicaid and CHIP and to provide guidance to States with respect to any new reporting requirements related to such improvements. Amounts appropriated under this paragraph shall remain available until expended.

(2) REQUIREMENTS.—The improvements made by the Secretary under paragraph (1) shall be designed and implemented (including with respect to any necessary guidance for States to report such information in a complete and expeditious manner) so that, beginning no later than October 1, 2009, data regarding the enrollment of low-income children (as defined in section 2110(c)(4) of the Social Security Act (42 U.S.C. 1397jj(c)(4)) of a State enrolled in the State plan under Medicaid or the State child health plan under CHIP with respect to a fiscal year shall be collected and analyzed by the Secretary within 6 months of submission.

(d) GAO STUDY AND REPORT ON ACCESS TO PRIMARY AND SPECIALITY SERVICES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including—

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

(B) information on such children's access to networks of care;

(C) geographic availability of primary and specialty services under such programs;

(D) the extent to which care coordination is provided for children's care under Medicaid and CHIP; and

(E) as appropriate, information on the degree of availability of services for children under such programs.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist.

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

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

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

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

TITLE V—IMPROVING ACCESS TO BENEFITS

SEC. 501. DENTAL BENEFITS.

(a) COVERAGE.—

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

(A) in subsection (a)—

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

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

(B) in subsection (c)—

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

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

''(5) DENTAL BENEFITS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) APPLICATION OF ENHANCED MATCH UNDER MEDICAID.—Section 1905 (42 U.S.C. 1396d) is amended—

(A) in subsection (b), in the fourth sentence, by striking ''or subsection (u)(3)'' and inserting '', (u)(3), or (u)(4)''; and

(B) in subsection (u)—

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

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

''(4) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for dental-only supplemental coverage for children described in section 2110(b)(5).''.

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

(d) PROVISION OF DENTAL SERVICES THROUGH FQHCS.—

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

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

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

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

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

(2) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397g(e)(1)), as amended by subsections (a)(2) and (d)(2) of section 203, is amended by inserting after subparagraph (B) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

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

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

(e) REPORTING INFORMATION ON DENTAL HEALTH.—

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

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

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

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

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

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

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

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

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

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

(1) work with States, pediatric dentists, and other dental providers (including providers that are, or are affiliated with, a school of dentistry) to include, not later than 6 months after the date of the enactment of this Act, on the Insure Kids Now website (http://www.insurekidsnow.gov/) and hotline (1–877–KIDS–NOW) (or on any successor websites or hotlines) a current and accurate list of all such dentists and providers within each State that provide dental services to children enrolled in the State plan (or waiver) under Medicaid or the State child health plan (or waiver) under CHIP, and shall ensure that such list is updated at least quarterly; and

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

(g) INCLUSION OF STATUS OF EFFORTS TO IMPROVE DENTAL CARE IN REPORTS ON THE QUALITY OF CHILDREN'S HEALTH CARE UNDER MEDICAID AND CHIP.—Section 1139A(a), as added by section 401(a), is amended—

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

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

(h) GAO STUDY AND REPORT.—

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

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

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

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

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

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

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

(2) REPORT.—Not later than 18 months year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to oral health care, including preventive and restorative services, under Medicaid and CHIP that may exist.

SEC. 502. MENTAL HEALTH PARITY IN CHIP PLANS.

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

''(6) MENTAL HEALTH SERVICES PARITY.—

''(A) IN GENERAL.—In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

''(B) DEEMED COMPLIANCE.—To the extent that a State child health plan includes coverage with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), such plan shall be deemed to satisfy the requirements of subparagraph (A).''.

(b) CONFORMING AMENDMENTS.—Section 2103 (42 U.S.C. 1397cc) is amended—

(1) in subsection (a), as amended by section 501(a)(1)(A)(i), in the matter preceding paragraph (1), by inserting '', (6),'' after ''(5)''; and

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

SEC. 503. APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) APPLICATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 501(c)(2) is amended by inserting after subparagraph (C) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

''(D) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services provided on or after October 1, 2009.

(b) TRANSITION GRANTS.—

(1) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2009, $5,000,000, to remain available until expended, for the purpose of awarding grants to States with State child health plans under CHIP that are operated separately from the State Medicaid plan under title XIX of the Social Security Act (including any waiver of such plan), or in combination with the State Medicaid plan, for expenditures related to transitioning to compliance with the requirement of section 2107(e)(1)(D) of the Social Security Act (as added by subsection (a)) to apply the prospective payment system established under section 1902(bb) of the such Act (42 U.S.C. 1396a(bb)) to services provided by Federally-qualified health centers and rural health clinics.

(2) MONITORING AND REPORT.—The Secretary shall monitor the impact of the application of such prospective payment system on the States described in paragraph (1) and, not later than October 1, 2011, shall report to Congress on any effect on access to benefits, provider payment rates, or scope of benefits offered by such States as a result of the application of such payment system.

SEC. 504. PREMIUM GRACE PERIOD.

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

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

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

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

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

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

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

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

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

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

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

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

''(9) SCHOOL-BASED HEALTH CENTER.—

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

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

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

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

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

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

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

''(i) A hospital.

''(ii) A public health department.

''(iii) A community health center.

''(iv) A nonprofit health care agency.

''(v) A school or school system.

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

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

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

''MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

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

''(b) DUTIES.—

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

''(A) review policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP') affecting children's access to covered items and services, including topics described in paragraph (2);

''(B) make recommendations to Congress concerning such access policies;

''(C) by not later than March 1 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

''(D) by not later than June 1 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

''(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

''(i) the factors affecting expenditures for items and services in different sectors, including the process for updating hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees;

''(ii) payment methodologies; and

''(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries.

''(B) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

''(C) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers.

''(3) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas or any other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.

''(4) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

''(5) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

''(6) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(7) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(8) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

''(9) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents

of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, health information technology, pediatric physicians, dentists, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include consumers representing children, pregnant women, the elderly, and individuals with disabilities, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

''(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

''(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

''(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of MACPAC;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

''(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

''(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.''.

(b) DEADLINE FOR INITIAL APPOINTMENTS.—Not later than January 1, 2010, the Comptroller General of the United States shall appoint the initial members of the Medicaid and CHIP Payment and Access Commission established under section 1900 of the Social Security Act (as added by subsection (a)).

(c) ANNUAL REPORT ON MEDICAID.—Not later than January 1, 2010, and annually thereafter, the Secretary, in consultation with the Secretary of the Treasury, the Secretary of Labor, and the States (as defined for purposes of Medicaid), shall submit an annual report to Congress on the financial status of, enrollment in, and spending trends for, Medicaid for the fiscal year ending on September 30 of the preceding year.

TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Subtitle A—Program Integrity and Data Collection

SEC. 601. PAYMENT ERROR RATE MEASUREMENT (''PERM'').

(a) EXPENDITURES RELATED TO COMPLIANCE WITH REQUIREMENTS.—

(1) ENHANCED PAYMENTS.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 301(a), is amended by adding at the end the following new paragraph:

''(11) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations) shall in no event be less than 90 percent.''.

(2) EXCLUSION OF FROM CAP ON ADMINISTRATIVE EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)C)), as amended by section 302(b)), is amended by adding at the end the following:

''(iv) PAYMENT ERROR RATE MEASUREMENT (PERM) EXPENDITURES.—Expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations).''.

(b) FINAL RULE REQUIRED TO BE IN EFFECT FOR ALL STATES.—Notwithstanding parts 431 and 457 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), the Secretary shall not calculate or publish any national or State-specific error rate based on the application of the payment error rate measurement (in this section referred to as ''PERM'') requirements to CHIP until after the date that is 6 months after the date on which a new final rule (in this section referred to as the ''new final rule'') promulgated after the date of the enactment of this Act and implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States. Any calculation of a national error rate or a State specific error rate after such new final rule in effect for all States may only be inclusive of errors, as defined in such new final rule or in guidance issued within a reasonable time frame after the effective date for such new final rule that includes detailed guidance for the specific methodology for error determinations.

(c) REQUIREMENTS FOR NEW FINAL RULE.—For purposes of subsection (b), the requirements of this subsection are that the new final rule implementing the PERM requirements shall—

(1) include—

(A) clearly defined criteria for errors for both States and providers;

(B) a clearly defined process for appealing error determinations by—

(i) review contractors; or

(ii) the agency and personnel described in section 431.974(a)(2) of title 42, Code of Federal Regulations, as in effect on September 1, 2007, responsible for the development, direction, implementation, and evaluation of eligibility reviews and associated activities; and

(C) clearly defined responsibilities and deadlines for States in implementing any corrective action plans; and

(2) provide that the payment error rate determined for a State shall not take into account payment errors resulting from the State's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant's self-declaration or self-certification satisfies the requirements for such process applicable under regulations promulgated by the Secretary or otherwise approved by the Secretary.

(d) OPTION FOR APPLICATION OF DATA FOR STATES IN FIRST APPLICATION CYCLE UNDER THE INTERIM FINAL RULE.—After the new final rule implementing the PERM requirements in accordance with the requirements of subsection (c) is in effect for all States, a State for which the PERM requirements were first in effect under an interim final rule for fiscal year 2007 or under a final rule for fiscal year 2008 may elect to accept any payment error rate determined in whole or in part for the State on the basis of data for that fiscal year or may elect to not have any payment error rate determined on the basis of such data and, instead, shall be treated as if fiscal year 2010 or fiscal year 2011 were the first fiscal year for which the PERM requirements apply to the State.

(e) HARMONIZATION OF MEQC AND PERM.—

(1) REDUCTION OF REDUNDANCIES.—The Secretary shall review the Medicaid Eligibility Quality Control (in this subsection referred to as the ''MEQC'') requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies.

(2) STATE OPTION TO APPLY PERM DATA.—A State may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the State for a fiscal year under section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) to substitute data resulting from the application of the PERM requirements to the State after the new final rule implementing such requirements is in effect for all States for data obtained from the application of the MEQC requirements to the State with respect to a fiscal year.

(3) STATE OPTION TO APPLY MEQC DATA.—For purposes of satisfying the requirements of subpart Q of part 431 of title 42, Code of Federal Regulations, relating to Medicaid eligibility reviews, a State may elect to substitute data obtained through MEQC reviews conducted in accordance with section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) for data required for purposes of PERM requirements, but only if the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States.

(f) IDENTIFICATION OF IMPROVED STATE-SPECIFIC SAMPLE SIZES.—The Secretary shall establish State-specific sample sizes for application of the PERM requirements with respect to State child health plans for fiscal years beginning with the first fiscal year that begins on or after the date on which the new final rule is in effect for all States, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable—

(1) minimize the administrative cost burden on States under Medicaid and CHIP; and

(2) maintain State flexibility to manage such programs.

SEC. 602. IMPROVING DATA COLLECTION.

(a) INCREASED APPROPRIATION.—Section 2109(b)(2) (42 U.S.C. 1397ii(b)(2)) is amended by striking ''$10,000,000 for fiscal year 2000'' and inserting ''$20,000,000 for fiscal year 2009''.

(b) USE OF ADDITIONAL FUNDS.—Section 2109(b) (42 U.S.C. 1397ii(b)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (2) as paragraph (4); and

(2) by inserting after paragraph (1), the following new paragraphs:

''(2) ADDITIONAL REQUIREMENTS.—In addition to making the adjustments required to produce the data described in paragraph (1), with respect to data collection occurring for fiscal years beginning with fiscal year 2009, in appropriate consultation with the Secretary of Health and Human Services, the Secretary of Commerce shall do the following:

''(A) Make appropriate adjustments to the Current Population Survey to develop more accurate State-specific estimates of the number of children enrolled in health coverage under title XIX or this title.

''(B) Make appropriate adjustments to the Current Population Survey to improve the survey estimates used to determine the child population growth factor under section 2104(m)(5)(B) and any other data necessary for carrying out this title.

''(C) Include health insurance survey information in the American Community Survey related to children.

''(D) Assess whether American Community Survey estimates, once such survey data are first available, produce more reliable estimates than the Current Population Survey with respect to the purposes described in subparagraph (B).

''(E) On the basis of the assessment required under subparagraph (D), recommend to the Secretary of Health and Human Services whether American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in subparagraph (B).

''(F) Continue making the adjustments described in the last sentence of paragraph (1) with respect to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.

''(3) AUTHORITY FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TRANSITION TO THE USE OF ALL, OR SOME COMBINATION OF, ACS ESTIMATES UPON RECOMMENDATION OF THE SECRETARY OF COMMERCE.—If, on the basis of the assessment required under paragraph (2)(D), the Secretary of Commerce recommends to the Secretary of Health and Human Services that American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in paragraph (2)(B), the Secretary of Health and Human Services, in consultation with the States, may provide for a period during which the Secretary may transition from carrying out such purposes through the use of Current Population Survey estimates to the use of American Community Survey estimates (in lieu of, or in combination with the Current Population Survey estimates, as recommended), provided that any such transition is implemented in a manner that is designed to avoid adverse impacts upon States with approved State child health plans under this title.''.

SEC. 603. UPDATED FEDERAL EVALUATION OF CHIP.

Section 2108(c) (42 U.S.C. 1397hh(c)) is amended by striking paragraph (5) and inserting the following:

''(5) SUBSEQUENT EVALUATION USING UPDATED INFORMATION.—

''(A) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

''(B) SELECTION OF STATES AND MATTERS INCLUDED.—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

''(C) SUBMISSION TO CONGRESS.—Not later than December 31, 2011, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

''(D) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2010 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2012.''.

SEC. 604. ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.

Section 2108(d) (42 U.S.C. 1397hh(d)) is amended to read as follows:

''(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.—For the purpose of evaluating and auditing the program established under this title, or title XIX, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal funds under this title and that are in the possession, custody, or control of States receiving Federal funds under this title or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.''.

SEC. 605. NO FEDERAL FUNDING FOR ILLEGAL ALIENS; DISALLOWANCE FOR UNAUTHORIZED EXPENDITURES.

Nothing in this Act allows Federal payment for individuals who are not legal residents. Titles XI, XIX, and XXI of the Social Security Act provide for the disallowance of Federal financial participation for erroneous expenditures under Medicaid and under CHIP, respectively.

Subtitle B—Miscellaneous Health Provisions

SEC. 611. DEFICIT REDUCTION ACT TECHNICAL CORRECTIONS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK BENEFIT PACKAGES UNDER MEDICAID.—Section 1937(a)(1) (42 U.S.C. 1396u–7(a)(1)), as inserted by section 6044(a) of the Deficit Reduction Act of 2005 (Public Law 109–171, 120 Stat. 88), is amended—

(1) in subparagraph (A)—

(A) in the matter before clause (i)—

(i) by striking ''Notwithstanding any other provision of this title'' and inserting ''Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability) and any other provision of this title which would be directly contrary to the authority under this section and subject to subsection (E)''; and

(ii) by striking ''enrollment in coverage that provides'' and inserting ''coverage that'';

(B) in clause (i), by inserting ''provides'' after ''(i)''; and

(C) by striking clause (ii) and inserting the following:

''(ii) for any individual described in section 1905(a)(4)(B) who is eligible under the State

plan in accordance with paragraphs (10) and (17) of section 1902(a), consists of the items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43).'';

(2) in subparagraph (C)—

(A) in the heading, by striking ''**WRAP-AROUND**'' and inserting ''**ADDITIONAL**''; and

(B) by striking ''wrap-around or''; and

(3) by adding at the end the following new subparagraph:

''(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

''(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);

''(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

''(iii) affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1905 and provided in accordance with section 1902(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.''.

(b) CORRECTION OF REFERENCE TO CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—Section 1937(a)(2)(B)(viii) (42 U.S.C. 1396u–7(a)(2)(B)(viii)), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by striking ''aid or assistance is made available under part B of title IV to children in foster care and individuals'' and inserting ''child welfare services are made available under part B of title IV on the basis of being a child in foster care or''.

(c) TRANSPARENCY.—Section 1937 (42 U.S.C. 1396u–7), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by adding at the end the following:

''(c) PUBLICATION OF PROVISIONS AFFECTED.—With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this title that the Secretary has determined do not apply in order to enable the State to carry out the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and not later than 30 days after such date of approval.''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) of this section shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

SEC. 612. REFERENCES TO TITLE XXI.

Section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, as enacted into law by division B of Public Law 106–113 (113 Stat. 1501A–402) is repealed.

SEC. 613. PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS.

After the date of the enactment of this Act, the Secretary of Health and Human Services may not approve any new demonstration programs under section 1938 of the Social Security Act (42 U.S.C. 1396u–8).

SEC. 614. ADJUSTMENT IN COMPUTATION OF MEDICAID FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.

(a) IN GENERAL.—Only for purposes of computing the FMAP (as defined in subsection (e)) for a State for a fiscal year (beginning with fiscal year 2006) and applying the FMAP under title XIX of the Social Security Act, any significantly disproportionate employer pension or insurance fund contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION AND INSURANCE FUND CONTRIBUTION.—

(1) IN GENERAL.—For purposes of this section, a significantly disproportionate employer pension and insurance fund contribution described in this subsection with respect to a State is any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such State for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that State for the year involved.

(2) DATA TO BE USED.—For estimating and adjustment a FMAP already calculated as of the date of the enactment of this Act for a State with a significantly disproportionate employer pension and insurance fund contribution, the Secretary shall use the personal income data set originally used in calculating such FMAP.

(3) SPECIAL ADJUSTMENT FOR NEGATIVE GROWTH.—If in any calendar year the total personal income growth in a State is negative, an employer pension and insurance fund contribution for the purposes of calculating the State's FMAP for a calendar year shall not exceed 125 percent of the amount of such contribution for the previous calendar year for the State.

(c) HOLD HARMLESS.—No State shall have its FMAP for a fiscal year reduced as a result of the application of this section.

(d) REPORT.—Not later than May 15, 2009, the Secretary shall submit to the Congress a report on the problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau of Economic Affairs calculations for the FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.

(e) FMAP DEFINED.—For purposes of this section, the term ''FMAP'' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396(d)).

SEC. 615. CLARIFICATION TREATMENT OF REGIONAL MEDICAL CENTER.

(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

(1) provides level 1 trauma and burn care services;

(2) provides level 3 neonatal care services;

(3) is obligated to serve all patients, regardless of ability to pay;

(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;

(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and

(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r–4) in at least one State other than the State in which the center is located.

SEC. 616. EXTENSION OF MEDICAID DSH ALLOTMENTS FOR TENNESSEE AND HAWAII.

Section 1923(f)(6) (42 U.S.C. 1396r–4(f)(6)), as amended by section 202 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended—

(1) in the paragraph heading, by striking ''2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010'' and inserting ''2011 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2012'';

(2) in subparagraph (A)—

(A) in clause (i)—

(i) in the second sentence—

(I) by striking ''and 2009'' and inserting '', 2009, 2010, and 2011''; and

(II) by striking ''such portion of''; and

(ii) in the third sentence, by striking ''2010 for the period ending on December 31, 2009'' and inserting ''2012 for the period ending on December 31, 2011'';

(B) in clause (ii), by striking ''or for a period in fiscal year 2010'' and inserting ''2010, 2011, or for period in fiscal year 2012''; and

(C) in clause (iv)—

(i) in the clause heading, by striking ''2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010'' and inserting ''2011 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2012''; and

(ii) in each of subclauses (I) and (II), by striking '' or for a period in fiscal year 2010'' and inserting ''2010, 2011, or for a period in fiscal year 2012''; and

(3) in subparagraph (B)—

(A) in clause (i)—

(i) in the first sentence, by striking ''2009'' and inserting ''2011''; and

(ii) in the second sentence, by striking ''2010 for the period ending on December 31, 2009'' and inserting ''2012 for the period ending on December 31, 2011''.

SEC. 617. GAO REPORT ON MEDICAID MANAGED CARE PAYMENT RATES.

Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives analyzing the extent to which State payment rates for medicaid managed care organizations under Medicaid are actuarially sound.

Subtitle C—Other Provisions

SEC. 621. OUTREACH REGARDING HEALTH INSURANCE OPTIONS AVAILABLE TO CHILDREN.

(a) DEFINITIONS.—In this section—

(1) the terms ''Administration'' and ''Administrator'' means the Small Business Administration and the Administrator thereof, respectively;

(2) the term ''certified development company'' means a development company participating in the program under title V of the Small Business Investment Act of 1958 (15 U.S.C. 695 et seq.);

(3) the term ''Medicaid program'' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(4) the term ''Service Corps of Retired Executives'' means the Service Corps of Retired Executives authorized by section 8(b)(1) of the Small Business Act (15 U.S.C. 637(b)(1));

(5) the term ''small business concern'' has the meaning given that term in section 3 of the Small Business Act (15 U.S.C. 632);

(6) the term ''small business development center'' means a small business development center described in section 21 of the Small Business Act (15 U.S.C. 648);

(7) the term ''State'' has the meaning given that term for purposes of title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(8) the term ''State Children's Health Insurance Program'' means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(9) the term ''task force'' means the task force established under subsection (b)(1); and

(10) the term ''women's business center'' means a women's business center described in section 29 of the Small Business Act (15 U.S.C. 656).

(b) ESTABLISHMENT OF TASK FORCE.—

(1) ESTABLISHMENT.—There is established a task force to conduct a nationwide campaign of education and outreach for small business concerns regarding the availability of coverage for children through private insurance options, the Medicaid program, and the State Children's Health Insurance Program.

(2) MEMBERSHIP.—The task force shall consist of the Administrator, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury.

(3) RESPONSIBILITIES.—The campaign conducted under this subsection shall include—

(A) efforts to educate the owners of small business concerns about the value of health coverage for children;

(B) information regarding options available to the owners and employees of small business concerns to make insurance more affordable, including Federal and State tax deductions and credits for health care-related expenses and health insurance expenses and Federal tax exclusion for health insurance options available under employer-sponsored cafeteria plans under section 125 of the Internal Revenue Code of 1986;

(C) efforts to educate the owners of small business concerns about assistance available through public programs; and

(D) efforts to educate the owners and employees of small business concerns regarding the availability of the hotline operated as part of the Insure Kids Now program of the Department of Health and Human Services.

(4) IMPLEMENTATION.—In carrying out this subsection, the task force may—

(A) use any business partner of the Administration, including—

(i) a small business development center;

(ii) a certified development company;

(iii) a women's business center; and

(iv) the Service Corps of Retired Executives;

(B) enter into—

(i) a memorandum of understanding with a chamber of commerce; and

(ii) a partnership with any appropriate small business concern or health advocacy group; and

(C) designate outreach programs at regional offices of the Department of Health and Human Services to work with district offices of the Administration.

(5) WEBSITE.—The Administrator shall ensure that links to information on the eligibility and enrollment requirements for the Medicaid program and State Children's Health Insurance Program of each State are prominently displayed on the website of the Administration.

(6) REPORT.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, and every 2 years thereafter, the Administrator shall submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives a report on the status of the nationwide campaign conducted under paragraph (1).

(B) CONTENTS.—Each report submitted under subparagraph (A) shall include a status update on all efforts made to educate owners and employees of small business concerns on options for providing health insurance for children through public and private alternatives.

SEC. 622. SENSE OF THE SENATE REGARDING ACCESS TO AFFORDABLE AND MEANINGFUL HEALTH INSURANCE COVERAGE.

(a) FINDINGS.—The Senate finds the following:

(1) There are approximately 45 million Americans currently without health insurance.

(2) More than half of uninsured workers are employed by businesses with less than 25 employees or are self-employed.

(3) Health insurance premiums continue to rise at more than twice the rate of inflation for all consumer goods.

(4) Individuals in the small group and individual health insurance markets usually pay more for similar coverage than those in the large group market.

(5) The rapid growth in health insurance costs over the last few years has forced many employers, particularly small employers, to increase deductibles and co-pays or to drop coverage completely.

(b) SENSE OF THE SENATE.—The Senate—

(1) recognizes the necessity to improve affordability and access to health insurance for all Americans;

(2) acknowledges the value of building upon the existing private health insurance market; and

(3) affirms its intent to enact legislation this year that, with appropriate protection for consumers, improves access to affordable and meaningful health insurance coverage for employees of small businesses and individuals by—

(A) facilitating pooling mechanisms, including pooling across State lines, and

(B) providing assistance to small businesses and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage.

TITLE VII—REVENUE PROVISIONS

SEC. 701. INCREASE IN EXCISE TAX RATE ON TOBACCO PRODUCTS.

(a) CIGARS.—Section 5701(a) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)'' in paragraph (1) and inserting ''$50.33 per thousand'',

(2) by striking ''20.719 percent (18.063 percent on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''52.75 percent'', and

(3) by striking ''$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''40.26 cents per cigar''.

(b) CIGARETTES.—Section 5701(b) of such Code is amended—

(1) by striking ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (1) and inserting ''$50.33 per thousand'', and

(2) by striking ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (2) and inserting ''$105.69 per thousand''.

(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)'' and inserting ''3.15 cents''.

(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)'' and inserting ''6.30 cents''.

(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended—

(1) by striking ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'' in paragraph (1) and inserting ''$1.51'', and

(2) by striking ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)'' in paragraph (2) and inserting ''50.33 cents''.

(f) PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)'' and inserting ''$2.8311 cents''.

(g) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking ''$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)'' and inserting ''$24.78''.

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products (other than cigars described in section 5701(a)(2) of the Internal Revenue Code of 1986) and cigarette papers and tubes manufactured in or imported into the United States which are removed before April 1, 2009, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of such Code on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on April 1, 2009, for which such person is liable.

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding tobacco products, cigarette papers, or cigarette tubes on April 1, 2009, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before August 1, 2009.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.) or any other provision of law, any article which is located in a foreign trade zone on April 1, 2009, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(5) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Any term used in this subsection which is also used in section 5702 of the Internal Revenue Code of 1986 shall have the same meaning as such term has in such section.

(B) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(6) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(7) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable

with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after March 31, 2009.

SEC. 702. ADMINISTRATIVE IMPROVEMENTS.

(a) PERMIT, INVENTORIES, REPORTS, AND RECORDS REQUIREMENTS FOR MANUFACTURERS AND IMPORTERS OF PROCESSED TOBACCO.—

(1) PERMIT.—

(A) APPLICATION.—Section 5712 of the Internal Revenue Code of 1986 is amended by inserting ''or processed tobacco'' after ''tobacco products''.

(B) ISSUANCE.—Section 5713(a) of such Code is amended by inserting ''or processed tobacco'' after ''tobacco products''.

(2) INVENTORIES, REPORTS, AND PACKAGES.—

(A) INVENTORIES.—Section 5721 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products''.

(B) REPORTS.—Section 5722 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products''.

(C) PACKAGES, MARKS, LABELS, AND NOTICES.—Section 5723 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products'' each place it appears.

(3) RECORDS.—Section 5741 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products''.

(4) MANUFACTURER OF PROCESSED TOBACCO.—Section 5702 of such Code is amended by adding at the end the following new subsection:

''(p) MANUFACTURER OF PROCESSED TOBACCO.—

''(1) IN GENERAL.—The term 'manufacturer of processed tobacco' means any person who processes any tobacco other than tobacco products.

''(2) PROCESSED TOBACCO.—The processing of tobacco shall not include the farming or growing of tobacco or the handling of tobacco solely for sale, shipment, or delivery to a manufacturer of tobacco products or processed tobacco.''.

(5) CONFORMING AMENDMENTS.—

(A) Section 5702(h) of such Code is amended by striking ''tobacco products and cigarette papers and tubes'' and inserting ''tobacco products or cigarette papers or tubes or any processed tobacco''.

(B) Sections 5702(j) and 5702(k) of such Code are each amended by inserting '', or any processed tobacco,'' after ''tobacco products or cigarette papers or tubes''.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on April 1, 2009.

(b) BASIS FOR DENIAL, SUSPENSION, OR REVOCATION OF PERMITS.—

(1) DENIAL.—Paragraph (3) of section 5712 of such Code is amended to read as follows:

''(3) such person (including, in the case of a corporation, any officer, director, or principal stockholder and, in the case of a partnership, a partner)—

''(A) is, by reason of his business experience, financial standing, or trade connections or by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, processed tobacco, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter,

''(B) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, processed tobacco, cigarette paper, or cigarette tubes, or

''(C) has failed to disclose any material information required or made any material false statement in the application therefor.''.

(2) SUSPENSION OR REVOCATION.—Subsection (b) of section 5713 of such Code is amended to read as follows:

''(b) SUSPENSION OR REVOCATION.—

''(1) SHOW CAUSE HEARING.—If the Secretary has reason to believe that any person holding a permit—

''(A) has not in good faith complied with this chapter, or with any other provision of this title involving intent to defraud,

''(B) has violated the conditions of such permit,

''(C) has failed to disclose any material information required or made any material false statement in the application for such permit,

''(D) has failed to maintain his premises in such manner as to protect the revenue,

''(E) is, by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, processed tobacco, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter, or

''(F) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, processed tobacco, cigarette paper, or cigarette tubes,

the Secretary shall issue an order, stating the facts charged, citing such person to show cause why his permit should not be suspended or revoked.

''(2) ACTION FOLLOWING HEARING.—If, after hearing, the Secretary finds that such person has not shown cause why his permit should not be suspended or revoked, such permit shall be suspended for such period as the Secretary deems proper or shall be revoked.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(c) APPLICATION OF INTERNAL REVENUE CODE STATUTE OF LIMITATIONS FOR ALCOHOL AND TOBACCO EXCISE TAXES.—

(1) IN GENERAL.—Section 514(a) of the Tariff Act of 1930 (19 U.S.C. 1514(a)) is amended by striking ''and section 520 (relating to refunds)'' and inserting ''section 520 (relating to refunds), and section 6501 of the Internal Revenue Code of 1986 (but only with respect to taxes imposed under chapters 51 and 52 of such Code)''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles imported after the date of the enactment of this Act.

(d) EXPANSION OF DEFINITION OF ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Section 5702(o) of the Internal Revenue Code of 1986 is amended by inserting ''or cigars, or for use as wrappers thereof'' before the period at the end.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after March 31, 2009.

(e) TIME OF TAX FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—

(1) IN GENERAL.—Section 5703(b)(2) of such Code is amended by adding at the end the following new subparagraph:

''(F) SPECIAL RULE FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—In the case of any tobacco products, cigarette paper, or cigarette tubes manufactured in the United States at any place other than the premises of a manufacturer of tobacco products, cigarette paper, or cigarette tubes that has filed the bond and obtained the permit required under this chapter, tax shall be due and payable immediately upon manufacture.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on the date of the enactment of this Act.

(f) DISCLOSURE.—

(1) IN GENERAL.—Paragraph (1) of section 6103(o) of such Code is amended by designating the text as subparagraph (A), moving such text 2 ems to the right, striking ''Returns'' and inserting ''(A) IN GENERAL.—Returns'', and by inserting after subparagraph (A) (as so redesignated) the following new subparagraph:

''(B) USE IN CERTAIN PROCEEDINGS.—Returns and return information disclosed to a Federal agency under subparagraph (A) may be used in an action or proceeding (or in preparation for such action or proceeding) brought under section 625 of the American Jobs Creation Act of 2004 for the collection of any unpaid assessment or penalty arising under such Act.''.

(2) CONFORMING AMENDMENT.—Section 6103(p)(4) of such Code is amended by striking ''(o)(1)'' both places it appears and inserting ''(o)(1)(A)''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply on or after the date of the enactment of this Act.

(g) TRANSITIONAL RULE.—Any person who—

(1) on April 1 is engaged in business as a manufacturer of processed tobacco or as an importer of processed tobacco, and

(2) before the end of the 90-day period beginning on such date, submits an application under subchapter B of chapter 52 of such Code to engage in such business, may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

SEC. 703. TREASURY STUDY CONCERNING MAGNITUDE OF TOBACCO SMUGGLING IN THE UNITED STATES.

Not later than one year after the date of the enactment of this Act, the Secretary of the Treasury shall conduct a study concerning the magnitude of tobacco smuggling in the United States and submit to Congress recommendations for the most effective steps to reduce tobacco smuggling. Such study shall also include a review of the loss of Federal tax receipts due to illicit tobacco trade in the United States and the role of imported tobacco products in the illicit tobacco trade in the United States.

SEC. 704. TIME FOR PAYMENT OF CORPORATE ESTIMATED TAXES.

The percentage under subparagraph (C) of section 401(1) of the Tax Increase Prevention and Reconciliation Act of 2005 in effect on the date of the enactment of this Act is increased by 0.5 percentage point.

SA 40. Mr. MCCONNELL (for himself, Mr. KYL, Mr. VITTER, Mr. CHAMBLISS, Mr. BUNNING, Mr. GREGG, Mr. COBURN, Mr. BURR, Mr. ISAKSON, Mr. GRAHAM, Mr. INHOFE, Mr. CORNYN, Mr. BROWNBACK, Mr. COCHRAN, Mr. ENSIGN, Mr. THUNE, Mr. DEMINT, Mr. BENNETT, Mr. BARRASSO, Mr. ENZI, and Mr. WICKER) proposed an amendment to amendment SA 39 proposed by Mr. REID (for Mr. BAUCUS) to 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; as follows:

In lieu of the matter proposed to be inserted insert

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Kids First Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Reauthorization through fiscal year 2013.
Sec. 3. Allotments for the 50 States and the District of Columbia based on expenditures and numbers of low-income children.
Sec. 4. Limitations on matching rates for populations other than low-income children or pregnant women covered through a section 1115 waiver.
Sec. 5. Prohibition on new section 1115 waivers for coverage of adults other than pregnant women.
Sec. 6. Standardization of determination of family income for targeted low-income children under title XXI and optional targeted low-income children under title XIX.
Sec. 7. Grants for outreach and enrollment.
Sec. 8. Improved State option for offering premium assistance for coverage of children through private plans under SCHIP and Medicaid.
Sec. 9. Treatment of unborn children.
Sec. 10. 50 percent matching rate for all Medicaid administrative costs.
Sec. 11. Reduction in payments for Medicaid administrative costs to prevent duplication of such payments under TANF.
Sec. 12. Elimination of waiver of certain Medicaid provider tax provisions.
Sec. 13. Elimination of special payments for certain public hospitals.
Sec. 14. Effective date; coordination of funding for fiscal year 2009.

SEC. 2. REAUTHORIZATION THROUGH FISCAL YEAR 2013.

(a) INCREASE IN NATIONAL ALLOTMENT.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (10);

(B) in paragraph (11)—

(i) by striking ''each of fiscal years 2008 and 2009'' and inserting ''fiscal year 2008''; and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new paragraphs:

''(12) for fiscal year 2009, $7,780,000,000;

''(13) for fiscal year 2010, $8,044,000,000;

''(14) for fiscal year 2011, $8,568,000,000;

''(15) for fiscal year 2012, $9,032,000,000; and

''(16) for fiscal year 2013, $9,505,000,000.''; and

(2) in subsection (c)(4)(B), by striking ''2009'' and inserting ''2008, $62,000,000 for fiscal year 2009, $64,000,000 for fiscal year 2010, $68,000,000 for fiscal year 2011, $72,000,000 for fiscal year 2012, and $75,000,000 for fiscal year 2013''.

(b) REPEAL OF LIMITATION ON AVAILABILITY OF FUNDING FOR FISCAL YEARS 2008 AND 2009.—Section 201 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended—

(1) in subsection (a), by striking paragraph (2) and redesignating paragraphs (3) and (4), as paragraphs (2) and (3) respectively; and

(2) in subsection (b), by striking paragraph (2).

SEC. 3. ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA BASED ON EXPENDITURES AND NUMBERS OF LOW-INCOME CHILDREN.

(a) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

''(m) DETERMINATION OF ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEARS 2009 THROUGH 2013.—

''(1) IN GENERAL.—Notwithstanding the preceding provisions of this subsection and subject to paragraph (3), the Secretary shall allot to each subsection (b) State for each of fiscal years 2009 through 2013, the amount determined for the fiscal year that is equal to the product of—

''(A) the amount available for allotment under subsection (a) for the fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year; and

''(B) the sum of the State allotment factors determined under paragraph (2) with respect to the State and weighted in accordance with subparagraph (B) of that paragraph for the fiscal year.

''(2) STATE ALLOTMENT FACTORS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the State allotment factors are the following:

''(i) The ratio of the projected expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the fiscal year to the sum of such projected expenditures for all States for the fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(ii) The ratio of the number of low-income children who have not attained age 19 with no health insurance coverage in the State, as determined by the Secretary on the basis of the arithmetic average of the number of such children for the 3 most recent Annual Social and Economic Supplements to the Current Population Survey of the Bureau of the Census available before the beginning of the calendar year before such fiscal year begins, to the sum of the number of such children determined for all States for such fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iii) The ratio of the projected expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the preceding fiscal year to the sum of such projected expenditures for all States for such preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iv) The ratio of the actual expenditures for targeted low-income children under the State child health plan and pregnant women under a waiver of such plan for the second preceding fiscal year to the sum of such actual expenditures for all States for such second preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(B) ASSIGNMENT OF WEIGHTS.—For each of fiscal years 2009 through 2013, the following percentage weights shall be applied to the ratios determined under subparagraph (A) for each such fiscal year:

''(i) 40 percent for the ratio determined under subparagraph (A)(i).

''(ii) 5 percent for the ratio determined under subparagraph (A)(ii).

''(iii) 50 percent for the ratio determined under subparagraph (A)(iii).

''(iv) 5 percent for the ratio determined under subparagraph (A)(iv).

''(C) DETERMINATION OF PROJECTED AND ACTUAL EXPENDITURES.—For purposes of subparagraph (A):

''(i) PROJECTED EXPENDITURES.—The projected expenditures described in clauses (i) and (iii) of such subparagraph with respect to a fiscal year shall be determined on the basis of amounts reported by States to the Secretary on the May 15th submission of Form CMS–37 and Form CMS–21B submitted not later than June 30th of the fiscal year preceding such year.

''(ii) ACTUAL EXPENDITURES.—The actual expenditures described in clause (iv) of such subparagraph with respect to a second preceding fiscal year shall be determined on the basis of amounts reported by States to the Secretary on Form CMS–64 and Form CMS–21 submitted not later than November 30 of the preceding fiscal year.''.

(b) 2-YEAR AVAILABILITY OF ALLOTMENTS; EXPENDITURES COUNTED AGAINST OLDEST ALLOTMENTS.—Section 2104(e) of the Social Security Act (42 U.S.C. 1397dd(e)) is amended to read as follows:

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

''(1) IN GENERAL.—Except as provided in the succeeding paragraphs of this subsection, amounts allotted to a State pursuant to this section—

''(A) for each of fiscal years 1998 through 2008, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

''(B) for each of fiscal years 2009 through 2013, shall remain available for expenditure by the State only through the end of the fiscal year succeeding the fiscal year for which such amounts are allotted.

''(2) ELIMINATION OF REDISTRIBUTION OF ALLOTMENTS NOT EXPENDED WITHIN 3 YEARS.—Notwithstanding subsection (f), amounts allotted to a State under this section for fiscal years beginning with fiscal year 2009 that remain unexpended as of the end of the fiscal year succeeding the fiscal year for which the amounts are allotted shall not be redistributed to other States and shall revert to the Treasury on October 1 of the third succeeding fiscal year.

''(3) RULE FOR COUNTING EXPENDITURES AGAINST FISCAL YEAR ALLOTMENTS.—Expenditures under the State child health plan made on or after April 1, 2009, shall be counted against allotments for the earliest fiscal year for which funds are available for expenditure under this subsection.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 2104(b)(1) of the Social Security Act (42 U.S.C. 1397dd(b)(1)) is amended by striking ''subsection (d)'' and inserting ''the succeeding subsections of this section''.

(2) Section 2104(f) of such Act (42 U.S.C. 1397dd(f)) is amended by striking ''The'' and inserting ''Subject to subsection (e)(2), the''.

SEC. 4. LIMITATIONS ON MATCHING RATES FOR POPULATIONS OTHER THAN LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.

(a) LIMITATION ON PAYMENTS.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATIONS ON MATCHING RATE FOR POPULATIONS OTHER THAN TARGETED LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.—For child health assistance or health benefits coverage furnished in any fiscal year beginning with fiscal year 2010:

''(A) FMAP APPLIED TO PAYMENTS FOR COVERAGE OF CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER ENROLLED IN THE STATE CHILD HEALTH PLAN ON THE DATE OF ENACTMENT OF THE KIDS FIRST ACT AND WHOSE GROSS FAMILY INCOME IS DETERMINED TO EXCEED THE INCOME ELIGIBILITY

LEVEL SPECIFIED FOR A TARGETED LOW-INCOME CHILD.—Notwithstanding subsections (b)(1)(B) and (d) of section 2110, in the case of any individual described in subsection (c) of section 105 of the Kids First Act who the State elects to continue to provide child health assistance for under the State child health plan in accordance with the requirements of such subsection, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to such assistance.

''(B) FMAP APPLIED TO PAYMENTS ONLY FOR NONPREGNANT CHILDLESS ADULTS AND PARENTS AND CARETAKER RELATIVES ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE KIDS FIRST ACT.—The Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to payments for child health assistance or health benefits coverage provided under the State child health plan for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES ENROLLED UNDER A WAIVER ON THE DATE OF ENACTMENT OF THE KIDS FIRST ACT.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project on the date of enactment of the Kids First Act and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(ii) NONPREGNANT CHILDLESS ADULTS ENROLLED UNDER A WAIVER ON SUCH DATE.—A nonpregnant childless adult enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project described in section 6102(c)(3) of the Deficit Reduction Act of 2005 (42 U.S.C. 1397gg note) on the date of enactment of the Kids First Act and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(iii) NO REPLACEMENT ENROLLEES.—Nothing in clauses (i) or (ii) shall be construed as authorizing a State to provide child health assistance or health benefits coverage under a waiver described in either such clause to a nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child, or a nonpregnant childless adult, who is not enrolled under the waiver on the date of enactment of the Kids First Act.

''(C) NO FEDERAL PAYMENT FOR ANY NEW NONPREGNANT ADULT ENROLLEES OR FOR SUCH ENROLLEES WHO NO LONGER SATISFY INCOME ELIGIBILITY REQUIREMENTS.—Payment shall not be made under this section for child health assistance or other health benefits coverage provided under the State child health plan or under a waiver under section 1115 for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES UNDER A SECTION 1115 WAIVER APPROVED AFTER THE DATE OF ENACTMENT OF THE KIDS FIRST ACT.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child under a waiver, experimental, pilot, or demonstration project that is approved on or after the date of enactment of the Kids First Act.

''(ii) PARENTS, CARETAKER RELATIVES, AND NONPREGNANT CHILDLESS ADULTS WHOSE FAMILY INCOME EXCEEDS THE INCOME ELIGIBILITY LEVEL SPECIFIED UNDER A SECTION 1115 WAIVER APPROVED PRIOR TO THE KIDS FIRST ACT.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child whose family income exceeds the income eligibility level referred to in subparagraph (B)(i), and any nonpregnant childless adult whose family income exceeds the income eligibility level referred to in subparagraph (B)(ii).

''(iii) NONPREGNANT CHILDLESS ADULTS, PARENTS, OR CARETAKER RELATIVES NOT ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE KIDS FIRST ACT.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(i) on the date of enactment of the Kids First Act, and any nonpregnant childless adult who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(ii)(I) on such date.

''(D) DEFINITION OF CARETAKER RELATIVE.—In this subparagraph, the term 'caretaker relative' has the meaning given that term for purposes of carrying out section 1931.

''(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as implying that payments for coverage of populations for which the Federal medical assistance percentage (as so determined) is to be substituted for the enhanced FMAP under subsection (a)(1) in accordance with this paragraph are to be made from funds other than the allotments determined for a State under section 2104.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) of the Social Security Act (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

SEC. 5. PROHIBITION ON NEW SECTION 1115 WAIVERS FOR COVERAGE OF ADULTS OTHER THAN PREGNANT WOMEN.

(a) IN GENERAL.—Section 2107(f) of the Social Security Act (42 U.S.C. 1397gg(f)) is amended—

(1) by striking '', the Secretary'' and inserting '':

''(1) The Secretary''; and

(2) by adding at the end the following new paragraphs:

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for any other adult other than a pregnant woman whose family income does not exceed the income eligibility level specified for a targeted low-income child in that State under a waiver or project approved as of such date.

''(3) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would waive or modify the requirements of section 2105(c)(8).''.

(b) CLARIFICATION OF AUTHORITY FOR COVERAGE OF PREGNANT WOMEN.—Section 2106 of the Social Security Act (42 U.S.C. 1397ff) is amended by adding at the end the following new subsection:

''(f) NO AUTHORITY TO COVER PREGNANT WOMEN THROUGH STATE PLAN.—For purposes of this title, a State may provide assistance to a pregnant woman under the State child health plan only—

''(1) by virtue of a waiver under section 1115; or

''(2) through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect on the date of enactment of the Kids First Act).''.

(c) ASSURANCE OF NOTICE TO AFFECTED ENROLLEES.—The Secretary of Health and Human Services shall establish procedures to ensure that States provide adequate public notice for parents, caretaker relatives, and nonpregnant childless adults whose eligibility for child health assistance or health benefits coverage under a waiver under section 1115 of the Social Security Act will be terminated as a result of the amendments made by subsection (a), and that States otherwise adhere to regulations of the Secretary relating to procedures for terminating waivers under section 1115 of the Social Security Act.

SEC. 6. STANDARDIZATION OF DETERMINATION OF FAMILY INCOME FOR TARGETED LOW-INCOME CHILDREN UNDER TITLE XXI AND OPTIONAL TARGETED LOW-INCOME CHILDREN UNDER TITLE XIX.

(a) ELIGIBILITY BASED ON GROSS INCOME.—

(1) IN GENERAL.—Section 2110 of the Social Security Act (42 U.S.C. 1397jj) is amended—

(A) in subsection (b)(1)(A), by inserting ''in accordance with subsection (d)'' after ''State plan''; and

(B) by adding at the end the following new subsection:

''(d) STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.—A State shall determine family income for purposes of determining income eligibility for child health assistance or other health benefits coverage under the State child health plan (or under a waiver of such plan under section 1115) solely on the basis of the gross income (as defined by the Secretary) of the family.''.

(2) PROHIBITION ON WAIVER OF REQUIREMENTS.—Section 2107(f) (42 U.S.C. 1397gg(f)), as amended by section 5(a), is amended by adding at the end the following new paragraph:

''(4) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Kids First Act that would waive or modify the requirements of section 2110(d) (relating to determining income eligibility on the basis of gross income) and regulations promulgated to carry out such requirements.''.

(b) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate interim final regulations defining gross income for purposes of section 2110(d) of the Social Security Act, as added by subsection (a).

(c) APPLICATION TO CURRENT ENROLLEES.—The interim final regulations promulgated under subsection (b) shall not be used to determine the income eligibility of any individual enrolled in a State child health plan under title XXI of the Social Security Act on the date of enactment of this Act before the date on which such eligibility of the individual is required to be redetermined under the plan as in effect on such date. In the case of any individual enrolled in such plan on such date who, solely as a result of the application of subsection (d) of section 2110 of the Social Security Act (as added by subsection (a)) and the regulations promulgated under subsection (b), is determined to be ineligible for child health assistance under the State child health plan, a State may elect, subject to substitution of the Federal medical assistance percentage for the enhanced FMAP under section 2105(c)(8)(A) of the Social Security Act (as added by section 4(a)), to continue to provide the individual with such assistance for so long as the individual otherwise would be eligible for such assistance and the individual's family income, if determined under the income and resource standards and methodologies applicable under the State child health plan on September 30,

2008, would not exceed the income eligibility level applicable to the individual under the State child health plan.

SEC. 7. GRANTS FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

''(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

''(1) IN GENERAL.—From the amounts appropriated for a fiscal year under subsection (f), subject to paragraph (2), the Secretary shall award grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

''(2) 10 PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts for the fiscal year shall be used by the Secretary for expenditures during the fiscal year to carry out a national enrollment campaign in accordance with subsection (g).

''(b) AWARD OF GRANTS.—

''(1) PRIORITY FOR AWARDING.—

''(A) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

''(i) propose to target geographic areas with high rates of—

''(I) eligible but unenrolled children, including such children who reside in rural areas; or

''(II) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

''(ii) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

''(B) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (f) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

''(2) 2-YEAR AVAILABILITY.—A grant awarded under this section for a fiscal year shall remain available for expenditure through the end of the succeeding fiscal year.

''(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

''(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

''(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

''(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

''(4) an assurance that the eligible entity shall—

''(A) conduct an assessment of the effectiveness of such activities against the performance measures;

''(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments.

''(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) SUPPLEMENT, NOT SUPPLANT.—Federal funds awarded under this section shall be used to supplement, not supplant, non-Federal funds that are otherwise available for activities funded under this section.

''(e) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

''(A) A State with an approved child health plan under this title.

''(B) A local government.

''(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

''(D) A Federal health safety net organization.

''(E) A State, national, local, or community-based public or nonprofit private organization.

''(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to non-governmental entities.

''(G) An elementary or secondary school.

''(H) A national, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.

''(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

''(A) a federally-qualified health center (as defined in section 1905(l)(2)(B));

''(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

''(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

''(D) any other entity or consortium that serves children under a federally-funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the head start and early head start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

''(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(4) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and health care agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with health care providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health or nutrition needs; and

''(F) by providing referral and followup services.

''(f) APPROPRIATION.—

''(1) IN GENERAL.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for the purpose of awarding grants under this section—

''(A) $100,000,000 for each of fiscal years 2009 and 2010;

''(B) $75,000,000 for each of fiscal years 2011 and 2012; and

''(C) $50,000,000 for fiscal year 2013.

''(2) GRANTS IN ADDITION TO OTHER AMOUNTS PAID.—Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

''(g) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2) for a fiscal year, the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

''(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

''(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

''(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

''(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

''(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

''(6) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.''.

(b) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2) of the Social Security Act (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following:

''(C) NONAPPLICATION TO EXPENDITURES FOR OUTREACH AND ENROLLMENT.—The limitation under subparagraph (A) shall not apply with respect to expenditures for outreach activities under section 2102(c)(1), or for enrollment activities, for children eligible for child health assistance under the State child health plan or medical assistance under the State plan under title XIX.''.

SEC. 8. IMPROVED STATE OPTION FOR OFFERING PREMIUM ASSISTANCE FOR COVERAGE OF CHILDREN THROUGH PRIVATE PLANS UNDER SCHIP AND MEDICAID.

(a) IN GENERAL.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)), as amended by section 4(a) is amended by adding at the end the following:

''(9) ADDITIONAL STATE OPTION FOR OFFERING PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a State

may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph.

''(B) QUALIFIED COVERAGE.—In this paragraph, the term 'qualified coverage' means the following:

''(i) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(I) IN GENERAL.—A group health plan or health insurance coverage offered through an employer that is—

''(aa) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(bb) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(cc) cost-effective, as determined under subclause (II).

''(II) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(aa) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(bb) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(ii) QUALIFIED NON-GROUP COVERAGE.—Health insurance coverage offered to individuals in the non-group health insurance market that is substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2).

''(iii) HIGH DEDUCTIBLE HEALTH PLAN.—A high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on February 1, 2009.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage;

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(b) APPLICATION TO MEDICAID.—Section 1906 of the Social Security Act (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) The provisions of section 2105(c)(9) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SEC. 9. TREATMENT OF UNBORN CHILDREN.

(a) CODIFICATION OF CURRENT REGULATIONS.—Section 2110(c)(1) of the Social Security Act (42 U.S.C. 1397jj(c)(1)) is amended by striking the period at the end and inserting the following: '', and includes, at the option of a State, an unborn child. For purposes of the previous sentence, the term 'unborn child' means a member of the species Homo sapiens, at any stage of development, who is carried in the womb.''.

(b) CLARIFICATIONS REGARDING COVERAGE OF MOTHERS.—Section 2103 (42 U.S.C. 1397cc) is amended by adding at the end the following new subsection:

''(g) CLARIFICATIONS REGARDING AUTHORITY TO PROVIDE POSTPARTUM SERVICES AND MATERNAL HEALTH CARE.—Any State that provides child health assistance to an unborn child under the option described in section 2110(c)(1) may—

''(1) continue to provide such assistance to the mother, as well as postpartum services, through the end of the month in which the

60-day period (beginning on the last day of pregnancy) ends; and

''(2) in the interest of the child to be born, have flexibility in defining and providing services to benefit either the mother or unborn child consistent with the health of both.''.

SEC. 10. 50 PERCENT MATCHING RATE FOR ALL MEDICAID ADMINISTRATIVE COSTS.

Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(1) by striking paragraph (2);

(2) by redesignating paragraph (3)(E) as paragraph (2) and re-locating and indenting it appropriately;

(3) in paragraph (2), as so redesignated, by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), and indenting them appropriately;

(4) by striking paragraphs (3) and (4);

(5) in paragraph (5), by striking ''which are attributable to the offering, arranging, and furnishing'' and inserting ''which are for the medical assistance costs of furnishing'';

(6) by striking paragraph (6);

(7) in paragraph (7), by striking ''subject to section 1919(g)(3)(B),''; and

(8) by redesignating paragraphs (5) and (7) as paragraphs (3) and (4), respectively.

SEC. 11. REDUCTION IN PAYMENTS FOR MEDICAID ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF SUCH PAYMENTS UNDER TANF.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(7), by striking ''section 1919(g)(3)(B)'' and inserting ''subsection (h)'';

(2) in subsection (a)(2)(D) by inserting '', subject to subsection (g)(3)(C) of such section'' after ''as are attributable to State activities under section 1919(g)''; and

(3) by adding after subsection (g) the following new subsection:

''(h) REDUCTION IN PAYMENTS FOR ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF PAYMENTS UNDER TITLE IV.—Beginning with the calendar quarter commencing April 1, 2009, the Secretary shall reduce the amount paid to each State under subsection (a)(7) for each quarter by an amount equal to ¼ of the annualized amount determined for the Medicaid program under section 16(k)(2)(B) of the Food Stamp Act of 1977 (7 U.S.C. 2025(k)(2)(B)).''.

SEC. 12. ELIMINATION OF WAIVER OF CERTAIN MEDICAID PROVIDER TAX PROVISIONS.

Effective October 1, 2009, subsection (c) of section 4722 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 515) is repealed.

SEC. 13. ELIMINATION OF SPECIAL PAYMENTS FOR CERTAIN PUBLIC HOSPITALS.

Effective October 1, 2009, subsection (d) of section 701 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554 (42 U.S.C. 1396r–4 note), is repealed.

SEC. 14. EFFECTIVE DATE; COORDINATION OF FUNDING FOR FISCAL YEAR 2009.

(a) IN GENERAL.—Unless otherwise specified, subject to subsection (b), the amendments made by this Act shall take effect on the date of enactment of this Act.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State child health plan under title XXI of the Social Security Act or a waiver of such plan under section 1115 of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan or waiver to meet the additional requirements imposed by the amendments made by this Act, the State child health plan or waiver shall not be regarded as failing to comply with the requirements of such title XXI solely on the basis of its failure to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(c) COORDINATION OF FUNDING FOR FISCAL YEAR 2009.—Notwithstanding any other provision of law, insofar as funds have been appropriated under section 2104(a)(11) of the Social Security Act, as amended by section 201(a) of Public Law 110–173 and in effect on January 1, 2009, to provide allotments to States under title XXI of the Social Security Act for fiscal year 2009—

(1) any amounts that are so appropriated that are not so allotted and obligated before the date of the enactment of this Act are rescinded; and

(2) any amount provided for allotments under title XXI of such Act to a State under the amendments made by this Act for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

SA 41. Mr. GRASSLEY (for himself, Mr. HATCH, Mr. ROBERTS, Mr. VITTER, and Mr. CHAMBLISS) proposed an amendment to amendment SA 39 proposed by Mr. REID (for Mr. BAUCUS) to 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; as follows:

Strike section 214 and insert the following:

SEC. 214. INCREASED FUNDING FOR ENROLLMENT OF UNINSURED LOW INCOME AMERICAN CHILDREN.

Section 2105(a)(3)(E) (42 U.S.C. 1397ee(a)(3)(E)), as added by section 104, is amended by adding at the end the following:

''(iv) INCREASE IN BONUS PAYMENTS FOR FISCAL YEARS 2012 THROUGH 2019.—With respect to each of fiscal years 2012 through 2019:

''(I) Clause (i) of subparagraph (B) shall be applied by substituting '38 percent' for '15 percent'.

''(II) Clause (ii) of subparagraph (B) shall be applied by substituting '70 percent' for '62.5 percent'.

SA 42. Mr. DEMINT submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

At the appropriate place, add the following:

TITLE __—HEALTH CARE CHOICE

SEC. __01. SHORT TITLE OF TITLE.

This title may be cited as ''Health Care Choice Act of 2009''.

SEC. __02. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This title is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. __03. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. __04. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

''PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

''SEC. 2795. DEFINITIONS.

''In this part:

''(1) PRIMARY STATE.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

''(2) SECONDARY STATE.—The term 'secondary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

''(3) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

''(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

''(5) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

''(6) HAZARDOUS FINANCIAL CONDITION.—The term 'hazardous financial condition' means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

''(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

''(B) to pay other obligations in the normal course of business.

''(7) COVERED LAWS.—

''(A) IN GENERAL.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

''(i) individual health insurance coverage issued by a health insurance issuer;

''(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

''(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

''(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

''(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

''(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

''(8) STATE.—The term 'State' means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term 'unfair claims settlement practices' means only the following practices:

''(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

''(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

''(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

''(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

''(E) Refusing to pay claims without conducting a reasonable investigation.

''(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

''(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

''(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

''(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

''(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

''(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the primary State.

''(10) FRAUD AND ABUSE.—The term 'fraud and abuse' means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

''(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

''(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

''(ii) The rating of an insurance policy or reinsurance contract.

''(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

''(iv) Premiums paid on an insurance policy or reinsurance contract.

''(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

''(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

''(vii) The financial condition of an insurer or reinsurer.

''(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

''(ix) The issuance of written evidence of insurance.

''(x) The reinstatement of an insurance policy.

''(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer, reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

''(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

''(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

''SEC. 2796. APPLICATION OF LAW.

''(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

''(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

''(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

''(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

''(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

''(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

''(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

''(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

''(D) to comply with a lawful order issued—

''(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

''(ii) in a voluntary dissolution proceeding;

''(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

''(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

''(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

''(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

''(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

''(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

''(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State's Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.''.

''(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

''(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

''(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

''(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

''(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

''(B) from raising premium rates for all policy holders within a class based on claims experience;

''(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

''(i) are disclosed to the consumer in the insurance contract;

''(ii) are based on specific wellness activities that are not applicable to all individuals; and

''(iii) are not obtainable by all individuals to whom coverage is offered;

''(D) from reinstating lapsed coverage; or

''(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

''(e) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

''(f) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

''(g) DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

''(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

''(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

''(B) written notice of any change in its designation of its primary State; and

''(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

''(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

''(A) a member of the American Academy of Actuaries; or

''(B) a qualified loss reserve specialist.

''(h) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

''(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

''(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (H) of section 2796(b)(1).

''(i) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

''(j) STATE POWERS TO ENFORCE STATE LAWS.—

''(1) IN GENERAL.—Subject to the provisions of subsection (b)(1)(G) (relating to injunctions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

''(2) COURTS OF COMPETENT JURISDICTION.—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

''(k) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(l) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

''(m) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

''SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

''A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

''SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

''(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless——

''(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

''(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the 'Health Carrier External Review Model Act' of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

''(b) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—In the case of any independent review mechanism referred to in subsection (a)(2)—

''(1) IN GENERAL.—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

''(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

''(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

''(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

''(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(3) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

''(i) not be a related party (as defined in paragraph (7));

''(ii) not have a material familial, financial, or professional relationship with such a party; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with the issuer, from serving as an independent medical reviewer if—

''(I) a non-affiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

''(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

''(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

''(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

''(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

''(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

''(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer to an independent medical reviewer in connection with a review under this section shall—

''(A) not exceed a reasonable level; and

''(B) not be contingent on the decision rendered by the reviewer.

''(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

''(A) The issuer involved, or any fiduciary, officer, director, or employee of the issuer.

''(B) The enrollee (or authorized representative).

''(C) The health care professional that provides the items or services involved in the denial.

''(D) The institution at which the items or services (or treatment) involved in the denial are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

''(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) ENROLLEE.—The term 'enrollee' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

''(B) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

''SEC. 2799. ENFORCEMENT.

''(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State's covered laws in the primary State and any secondary State.

''(b) SECONDARY STATE'S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

''(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

''(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

(E) cases of fraud or abuse relating to health insurance coverage offered under such amendment and the resolution of such cases.

(2) ANNUAL REPORTS.—The Comptroller General shall submit to Congress an annual report, after the end of each of the 5 years following the effective date of the amendment made by subsection (a), on the ongoing study conducted under paragraph (1).

SEC. __05. SEVERABILITY.

If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any other person or circumstance shall not be affected.

SA 43. Mr. DEMINT submitted an amendment intended to be proposed to amendment SA 39 proposed by Mr. REID (for Mr. BAUCUS) to 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; as follows:

At the appropriate place, add the following:

SEC. ___. REQUIRED COST-SHARING FOR HIGHER INCOME INDIVIDUALS.

Section 2103(e) (42 U.S.C. 1397cc(e)) is amended—

(1) in paragraph (3)(B), by striking ''and (2)'' and inserting '', (2), and (5)'';

(2) in paragraph (4), by striking ''Nothing'' and inserting ''Except as provided in paragraph (5), nothing''; and

(3) by adding at the end the following new paragraph:

''(5) REQUIRED COST-SHARING FOR HIGHER INCOME INDIVIDUALS.—Subject to paragraphs (1)(B) and (2), a State child health plan shall impose premiums, deductibles, coinsurance, and other cost-sharing (regardless of whether such plan is implemented under this title, title XIX, or both) for any targeted low-income child or other individual enrolled in the plan whose family income exceeds 200 percent of the poverty line in a manner that is consistent with the authority and limitations for imposing cost-sharing under section 1916A.''.

SA 44. Mr. DEMINT (for himself and Mr. VITTER) submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. —. PROHIBITION ON CONSIDERATION OF REVENUE PROVISIONS WITHOUT CERTIFICATION OF TAX BURDEN EFFECTS.

(a) IN GENERAL.—It shall not be in order to consider a bill, resolution, amendment, or conference report that proposes any provision amending the Internal Revenue Code of 1986 or affecting the application of such Code unless the Joint Committee on Taxation provides a written certification that such provision does not increase the net yearly tax burden for any family whose taxable income for any taxable year to which such provision applies is less than $250,000.

(b) SUPERMAJORITY WAIVER AND APPEAL.—

(1) WAIVER.—A point of order raised under subsection (a) may be waived or suspended in the Senate only by an affirmative vote of two-thirds of the Members, duly chosen and sworn.

(2) APPEAL.—An affirmative vote of two-thirds of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under subsection (a).

(c) DEFINITION.—For purposes of this section, the term ''family'' means a married couple filing jointly or an individual filing as a head of household.

SA 45. Mr. HATCH (for himself, Mr. GRASSLEY, and Mr. WICKER) proposed an amendment to amendment SA 39 proposed by Mr. REID (for Mr. BAUCUS) to 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; as follows:

On page 136, between lines 15 and 16, insert the following:

(c) CONDITION FOR FEDERAL MATCHING PAYMENTS.—

(1) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) in paragraph (23), by striking ''or'' after the semicolon;

(B) in paragraph (24)(C), by striking the period and inserting ''; or''; and

(C) by inserting after paragraph (24)(C), the following:

''(25) with respect to amounts expended for medical assistance for an immigrant child or pregnant woman under an election made pursuant to paragraph (4) of subsection (v) for any fiscal year quarter occurring before the first fiscal year quarter for which the State demonstrates to the Secretary (on the basis of the best data reasonably available to the Secretary and in accordance with such techniques for sampling and estimating as the Secretary determines appropriate) that the State has enrolled in the State plan under this title, the State child health plan under title XXI, or under a waiver of either such plan, at least 95 percent of the children who reside in the State, whose family income (as determined without regard to the application of any general exclusion or disregard of a block of income that is not determined by type of expense or type of income (regardless of whether such an exclusion or disregard is

permitted under section 1902(r))) does not exceed 200 percent of the poverty line (as defined in section 2110(c)(5)), and who are eligible for medical assistance under the State plan under this title or child health assistance or health benefits coverage under the State child health plan under title XXI.''.

(2) APPLICATION TO CHIP.—Section 2107(e)(1)(E) (42 U.S.C. 1397gg(e)(1)(E)) (as amended by section 503(a)(1)) is amended by striking ''and (17)'' and inserting ''(17), and (25)''.

SA 46. Mr. KYL submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 76, after line 23, add the following:

SEC. 116. PREVENTING SUBSTITUTION OF CHIP COVERAGE FOR PRIVATE COVERAGE.

(a) FINDINGS.—

(1) Congress agrees with the President that low-income children should be the first priority of all States in providing child health assistance under CHIP.

(2) Congress agrees with the President and the Congressional Budget Office that the substitution of CHIP coverage for private coverage occurs more frequently for children in families at higher income levels.

(3) Congress agrees with the President that it is appropriate that States that expand CHIP eligibility to children at higher income levels should have achieved a high level of health benefits coverage for low-income children and should implement strategies to address such substitution.

(4) Congress concludes that the policies specified in this section (and the amendments made by this section) are the appropriate policies to address these issues.

(b) ANALYSES OF BEST PRACTICES AND METHODOLOGY IN ADDRESSING CROWD-OUT.—

(1) GAO REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives and the Secretary a report describing the best practices by States in addressing the issue of CHIP crowd-out. Such report shall include analyses of—

(A) the impact of different geographic areas, including urban and rural areas, on CHIP crowd-out;

(B) the impact of different State labor markets on CHIP crowd-out;

(C) the impact of different strategies for addressing CHIP crowd-out;

(D) the incidence of crowd-out for children with different levels of family income; and

(E) the relationship (if any) between changes in the availability and affordability of dependent coverage under employer-sponsored health insurance and CHIP crowd-out.

(2) IOM REPORT ON METHODOLOGY.—The Secretary shall enter into an arrangement with the Institute of Medicine under which the Institute submits to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives and the Secretary, not later than 18 months after the date of the enactment of this Act, a report on—

(A) the most accurate, reliable, and timely way to measure—

(i) on a State-by-State basis, the rate of public and private health benefits coverage among low-income children with family income that does not exceed 200 percent of the poverty line; and

(ii) CHIP crowd-out, including in the case of children with family income that exceeds 200 percent of the poverty line; and

(B) the least burdensome way to gather the necessary data to conduct the measurements described in subparagraph (A).

Out of any money in the Treasury not otherwise appropriated, there are hereby appropriated $2,000,000 to carry out this paragraph for the period ending September 30, 2010.

(3) INCORPORATION OF DEFINITIONS.—In this section, the terms ''CHIP crowd-out'', ''children'', ''poverty line'', and ''State'' have the meanings given such terms for purposes of CHIP.

(4) DEFINITION OF CHIP CROWD-OUT.—Section 2110(c) (42 U.S.C. 1397jj(c)) is amended by adding at the end the following:

''(9) CHIP CROWD-OUT.—The term 'CHIP crowd-out' means the substitution of—

''(A) health benefits coverage for a child under this title, for

''(B) health benefits coverage for the child other than under this title or title XIX.''.

(c) DEVELOPMENT OF BEST PRACTICE RECOMMENDATIONS.—Section 2107 (42 U.S.C. 1397gg) is amended by adding at the end the following:

''(g) DEVELOPMENT OF BEST PRACTICE RECOMMENDATIONS.—Within 6 months after the date of receipt of the reports under subsections (a) and (b) of section 116 of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary, in consultation with States, including Medicaid and CHIP directors in States, shall publish in the Federal Register, and post on the public website for the Department of Health and Human Services—

''(1) recommendations regarding best practices for States to use to address CHIP crowd-out; and

''(2) uniform standards for data collection by States to measure and report—

''(A) health benefits coverage for children with family income below 200 percent of the poverty line; and

''(B) on CHIP crowd-out, including for children with family income that exceeds 200 percent of the poverty line.

The Secretary, in consultation with States, including Medicaid and CHIP directors in States, may from time to time update the best practice recommendations and uniform standards set published under paragraphs (1) and (2) and shall provide for publication and posting of such updated recommendations and standards.''.

(d) REQUIREMENT TO ADDRESS CHIP CROWD-OUT; SECRETARIAL REVIEW.—Section 2106 (42 U.S.C. 1397ff) is amended by adding at the end the following:

''(f) REQUIREMENT TO ADDRESS CHIP CROWD-OUT; SECRETARIAL REVIEW.—

''(1) IN GENERAL.—Not later than 6 months after the best practice application date described in paragraph (2), each State that has a State child health plan shall submit to the Secretary a State plan amendment describing how the State—

''(A) will address CHIP crowd-out; and

''(B) will incorporate recommended best practices referred to in such paragraph.

''(2) BEST PRACTICE APPLICATION DATE.—The best practice application date described in this paragraph is the date that is 6 months after the date of publication of recommendations regarding best practices under section 2107(g)(1).

''(3) SECRETARIAL REVIEW.—The Secretary shall—

''(A) review each State plan amendment submitted under paragraph (1);

''(B) determine whether the amendment incorporates recommended best practices referred to in paragraph (2);

''(C) in the case of a higher income eligibility State (as defined in section 2105(c)(9)(B)), determine whether the State meets the enrollment targets required under reference section 2105(c)(9)(C); and

''(D) notify the State of such determinations.''.

(e) LIMITATION ON PAYMENTS FOR STATES COVERING HIGHER INCOME CHILDREN.—

(1) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 114(a), is amended by adding at the end the following new paragraph:

''(9) LIMITATION ON PAYMENTS FOR STATES COVERING HIGHER INCOME CHILDREN.—

''(A) DETERMINATIONS.—

''(i) IN GENERAL.—The Secretary shall determine, for each State that is a higher income eligibility State as of April 1 of 2011 and each subsequent year, whether the State meets the target rate of coverage of low-income children required under subparagraph (C) and shall notify the State in that month of such determination.

''(ii) DETERMINATION OF FAILURE.—If the Secretary determines in such month that a higher income eligibility State does not meet such target rate of coverage, subject to subparagraph (E), no payment shall be made as of October 1 of such year on or after October 1, 2011, under this section for child health assistance provided for higher-income children (as defined in subparagraph (D)) under the State child health plan unless and until the State establishes it is in compliance with such requirement.

''(B) HIGHER INCOME ELIGIBILITY STATE.—A higher income eligibility State described in this clause is a State that—

''(i) applies under its State child health plan an eligibility income standard for targeted low-income children that exceeds 300 percent of the poverty line; or

''(ii) because of the application of a general exclusion of a block of income that is not determined by type of expense or type of income, applies an effective income standard under the State child health plan for such children that exceeds 300 percent of the poverty line.

''(C) REQUIREMENT FOR TARGET RATE OF COVERAGE OF LOW-INCOME CHILDREN.—

''(i) IN GENERAL.—The requirement of this subparagraph for a State is that the rate of health benefits coverage (both private and public) for low-income children in the State is not statistically significantly (at a p=0.05 level) less than the target rate of coverage specified in clause (ii).

''(ii) TARGET RATE.—The target rate of coverage specified in this clause is the average rate (determined by the Secretary) of health benefits coverage (both private and public) as of January 1, 2011, among the 10 of the 50 States and the District of Columbia with the highest percentage of health benefits coverage (both private and public) for low-income children.

''(iii) STANDARDS FOR DATA.—In applying this subparagraph, rates of health benefits coverage for States shall be determined using the uniform standards identified by the Secretary under section 2107(g)(2).

''(D) HIGHER-INCOME CHILD.—For purposes of this paragraph, the term 'higher income child' means, with respect to a State child health plan, a targeted low-income child whose family income—

''(i) exceeds 300 percent of the poverty line; or

''(ii) would exceed 300 percent of the poverty line if there were not taken into account any general exclusion described in subparagraph (B)(ii).

''(E) NOTICE AND OPPORTUNITY TO COMPLY WITH TARGET RATE.—If the Secretary makes a determination described in subparagraph (A)(ii) in April of a year, the Secretary—

''(i) shall provide the State with the opportunity to submit and implement a corrective

action plan for the State to come into compliance with the requirement of subparagraph (C) before October 1 of such year;

''(ii) shall not effect a denial of payment under subparagraph (A) on the basis of such determination before October 1 of such year; and

''(iii) shall not effect such a denial if the Secretary determines that there is a reasonable likelihood that the implementation of such a correction action plan will bring the State into compliance with the requirement of subparagraph (C).''.

(2) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) or this section this shall be construed as authorizing the Secretary to limit payments under title XXI of the Social Security Act in the case of a State that is not a higher income eligibility State (as defined in section 2105(c)(9)(B) of such Act, as added by paragraph (1)).

(f) TREATMENT OF MEDICAL SUPPORT ORDERS.—Section 2102(b) (42 U.S.C. 1397bb(c)) is amended by adding at the end the following:

''(5) TREATMENT OF MEDICAL SUPPORT ORDERS.—

''(A) IN GENERAL.—Nothing in this title shall be construed to allow the Secretary to require that a State deny eligibility for child health assistance to a child who is otherwise eligible on the basis of the existence of a valid medical support order being in effect.

''(B) STATE ELECTION.—A State may elect to limit eligibility for child health assistance to a targeted low-income child on the basis of the existence of a valid medical support order on the child's behalf, but only if the State does not deny such eligibility for a child on such basis if the child asserts that the order is not being complied with for any of the reasons described in subparagraph (C) unless the State demonstrates that none of such reasons applies in the case involved.

''(C) REASONS FOR NONCOMPLIANCE.—The reasons described in this subparagraph for noncompliance with a medical support order with respect to a child are that the child is not being provided health benefits coverage pursuant to such order because—

''(i) of failure of the noncustodial parent to comply with the order;

''(ii) of the failure of an employer, group health plan or health insurance issuer to comply with such order; or

''(iii) the child resides in a geographic area in which benefits under the health benefits coverage are generally unavailable.''.

(g) EFFECTIVE DATE OF AMENDMENTS; CONSISTENCY OF POLICIES.—The amendments made by this section shall take effect as if enacted on August 16, 2007. The Secretary may not impose (or continue in effect) any requirement, prevent the implementation of any provision, or condition the approval of any provision under any State child health plan, State plan amendment, or waiver request on the basis of any policy or interpretation relating to CHIP crowd-out, coordination with other sources of coverage, target rate of coverage, or medical support order other than under the amendments made by this section. In the case of a State plan amendment which was denied on or after August 16, 2007, on the basis of any such policy or interpretation in effect before the date of the enactment of this Act, if the State submits a modification of such State plan amendment that complies with title XXI of the Social Security Act as amended by this Act, such submitted State plan amendment, as so modified, shall be considered as if it had been submitted (as so modified) as of the date of its original submission, but such State plan amendment shall not be effective before the date of the enactment of this Act.

SA 47. Mr. COBURN (for himself and Mr. THUNE) submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 153, between lines 3 and 4, insert the following:

(c) REQUIRED OFFERING OF PREMIUM ASSISTANCE FOR COVERAGE OF CHILDREN THROUGH PRIVATE PLANS UNDER SCHIP AND MEDICAID IF THE STATE EXPANDS THEIR PROGRAM BEYOND CURRENT ELIGIBILITY LEVELS.—

(1) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 601, is amended by adding at the end the following:

''(12) REQUIRED OFFERING OF PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, the child health assistance provided to any child whose family income exceeds the income eligibility level in effect under the State children's plan as of January 1, 2009, shall consist of a State premium assistance subsidy (as defined in subparagraph (C)) for qualified coverage (as defined in subparagraph (B)) in accordance with the requirements of this paragraph.

''(B) QUALIFIED COVERAGE.—In this paragraph, the term 'qualified coverage' means the following:

''(i) QUALIFIED EMPLOYER SPONSORED COVERAGE.—

''(I) IN GENERAL.—A group health plan or health insurance coverage offered through an employer that is—

''(aa) substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2);

''(bb) made similarly available to all of the employer's employees and for which the employer makes a contribution to the premium that is not less for employees receiving a premium assistance subsidy under any option available under the State child health plan under this title or the State plan under title XIX to provide such assistance than the employer contribution provided for all other employees; and

''(cc) cost-effective, as determined under subclause (II).

''(II) COST-EFFECTIVENESS.—A group health plan or health insurance coverage offered through an employer shall be considered to be cost-effective if—

''(aa) the marginal premium cost to purchase family coverage through the employer is less than the State cost of providing child health assistance through the State child health plan for all the children in the family who are targeted low-income children; or

''(bb) the marginal premium cost between individual coverage and purchasing family coverage through the employer is not greater than 175 percent of the cost to the State to provide child health assistance through the State child health plan for a targeted low-income child.

''(ii) QUALIFIED NON-GROUP COVERAGE.—Health insurance coverage offered to individuals in the non-group health insurance market that is substantially equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2).

''(iii) HIGH DEDUCTIBLE HEALTH PLAN.—A high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code).

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan, subject to the annual aggregate cost-sharing limit applied under section 2103(e)(3)(B).

''(ii) STATE PAYMENT OPTION.—Subject to clause (iii), a State may provide a premium assistance subsidy directly to an employer or as reimbursement to an employee for out-of-pocket expenditures.

''(iii) REQUIREMENT FOR DIRECT PAYMENT TO EMPLOYEE.—A State shall not pay a premium assistance subsidy directly to the employee, unless the State has established procedures to ensure that the targeted low-income child on whose behalf such payments are made are actually enrolled in the qualified employer sponsored coverage.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(v) STATE OPTION TO REQUIRE ACCEPTANCE OF SUBSIDY.—A State may condition the provision of child health assistance under the State child health plan for a targeted low-income child on the receipt of a premium assistance subsidy for enrollment in qualified employer sponsored coverage if the State determines the provision of such a subsidy to be more cost-effective in accordance with subparagraph (B)(ii).

''(vi) NOT TREATED AS INCOME.—Notwithstanding any other provision of law, a premium assistance subsidy provided in accordance with this paragraph shall not be treated as income to the child or the parent of the child for whom such subsidy is provided.

''(D) NO REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND ADDITIONAL COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—A State that elects the option to provide a premium assistance subsidy under this paragraph shall not be required to provide a targeted low-income child enrolled in qualified employer sponsored coverage with supplemental coverage for items or services that are not covered, or are only partially covered, under the qualified employer sponsored coverage or cost-sharing protection other than the protection required under section 2103(e)(3)(B).

''(ii) NOTICE OF COST-SHARING REQUIREMENTS.—A State shall provide a targeted low-income child or the parent of such a child (as appropriate) who is provided with a premium assistance subsidy in accordance with this paragraph with notice of the cost-sharing requirements and limitations imposed under the qualified employer sponsored coverage in which the child is enrolled upon the enrollment of the child in such coverage and annually thereafter.

''(iii) RECORD KEEPING REQUIREMENTS.—A State may require a parent of a targeted low-income child that is enrolled in qualified employer-sponsored coverage to bear the responsibility for keeping track of out-of-pocket expenditures incurred for cost-sharing imposed under such coverage and to notify the State when the limit on such expenditures imposed under section 2103(e)(3)(B) has been reached for a year from the effective date of enrollment for such year.

''(iv) STATE OPTION FOR REIMBURSEMENT.—A State may retroactively reimburse a parent of a targeted low-income child for out-of-pocket expenditures incurred after reaching the 5 percent cost-sharing limitation imposed under section 2103(e)(3)(B) for a year.

''(E) 6-MONTH WAITING PERIOD REQUIRED.—A State shall impose at least a 6-month waiting period from the time an individual is enrolled in private health insurance prior to the provision of a premium assistance subsidy for a targeted low-income child in accordance with this paragraph.

''(F) NON APPLICATION OF WAITING PERIOD FOR ENROLLMENT IN THE STATE MEDICAID PLAN OR THE STATE CHILD HEALTH PLAN.—A targeted low-income child provided a premium assistance subsidy in accordance with this paragraph who loses eligibility for such subsidy shall not be treated as having been enrolled in private health insurance coverage for purposes of applying any waiting period imposed under the State child health plan or the State plan under title XIX for the enrollment of the child under such plan.

''(G) ASSURANCE OF SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF ELIGIBILITY FOR PREMIUM SUBSIDY ASSISTANCE.—No payment shall be made under subsection (a) for amounts expended for the provision of premium assistance subsidies under this paragraph unless a State provides assurances to the Secretary that the State has in effect laws requiring a group health plan, a health insurance issuer offering group health insurance coverage in connection with a group health plan, and a self-funded health plan, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a child of such an employee if the child is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the employee's child becomes eligible for a premium assistance subsidy under this paragraph.

''(H) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect on February 1, 2009.

''(I) NOTICE OF AVAILABILITY.—A State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer sponsored coverage;

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are informed of the availability of such subsidies under the State child health plan.''.

(2) APPLICATION TO MEDICAID.—Section 1906 (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) The provisions of section 2105(c)(12) shall apply to a child who is eligible for medical assistance under the State plan in the same manner as such provisions apply to a targeted low-income child under a State child health plan under title XXI. Section 1902(a)(34) shall not apply to a child who is provided a premium assistance subsidy under the State plan in accordance with the preceding sentence.''.

SA 48. Mr. COBURN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. COMPLIANCE WITH STATE PARENTAL NOTIFICATION AND CONSENT LAWS.

Notwithstanding any other provision of law, no Federal funds shall be made available under this Act (or an amendment made by this Act) to a health care provider to reimburse such provider for services provided to a minor unless such provider complies with all applicable parental notification and consent laws of the State of residence of the minor.

SA 49. Mr. COBURN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Strike section 602 and insert the following:

SEC. 602. LIMITATION ON EXPANSION.

Section 2105(c)(8) (42 U.S.C. 1397ee(c)(8)), as added by section 114(a), is amended by adding at the end the following:

''(C) REQUIREMENT.—Notwithstanding subparagraphs (A) and (B), on or after the date of enactment of this subparagraph, the Secretary may not approve a State plan amendment or waiver for child health assistance or health benefits to children whose family income exceeds 300 percent of the poverty line unless the improper payment rate for Medicaid and CHIP (as measured by the payment error rate measurement (PERM)) is equal to or is less than 3.5 percent.''.

SA 50. Mr. COBURN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

At the end of section 601, add the following:

(g) TIME FOR PROMULGATION OF FINAL RULE.—The final rule implementing the PERM requirements under subsection (b) shall be promulgated not later than 6 months after the date of enactment of this Act.

SA 51. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 93, between lines 16 and 17, insert the following:

''(VI) ATTESTATION.—The State requires that an application for medical assistance under this title or for child health assistance under title XXI shall not be complete until the parent or guardian of the child for whose eligibility the State is relying on a finding from an Express Lane agency attests under penalty of perjury that the information provided to verify the citizenship or nationality of the child is accurate, to the best of the parent's or guardian's knowledge.

SA 52. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 130, between lines 7 and 8, insert the following:

(d) GAO STUDY AND REPORT.—The Comptroller General or the United States shall study and report to Congress on the extent to which States use the option to provide presumptive eligibility for medical assistance under Medicaid or child health assistance under CHIP to avoid complying with the verification of citizenship or nationality documentation requirements of section 1903(x) of the Social Security Act or any other eligibility requirements for receipt of medical assistance or child health assistance.

SA 53. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 93, between lines 16 and 17, insert the following:

''(VI) NOTICE AND AFFIRMATIVE CONSENT.—The State requires an Express Lane Agency to provide affirmative notice and obtain consent in the form of a signature from all potential enrollees in the State plan under this title or title XXI (or the parent or guardian of a potential enrollee, in the case of a child under age 18) that the information gathered for purposes of applying for a specific program administered by the Express Lane Agency may also be used for purposes of determining one or more components of eligibility for medical assistance under this title or for child health assistance under title XXI.

SA 54. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 93, lines 12 and 13, strike ''1902(a)(46)(B) or 2105(c)(9), as applicable'' and insert ''1903(x)''.

SA 55. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Beginning on page 121, strike line 20, and all that follows through page 122, line 20, and insert the following:

''(B) Payments under the State plan for providing medical assistance to individuals who provided inconsistent information and were provided with a reasonable period of time to resolve the inconsistency under this subsection or under section 1903(x)(4) shall be included in the determination of the State's erroneous excess payments for medical assistance ratio under section 1903(u).

SA 56. Mr. GRASSLEY submitted an amendment intended to be proposed by

him to 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; which was ordered to lie on the table; as follows:

On page 135, strike lines 14 through 20, and insert the following:

''(B) In the case of a State that has elected to provide medical assistance to a category of individuals under subparagraph (A), the Secretary may impose a debt under an affidavit of support against any sponsor of such an individual on the basis of the provision of medical assistance to such individual, consisting of all or a portion of the cost of providing such assistance, which may include a reasonable fee, and which shall be considered as an unreimbursed cost, subject to such limit on the total amount of debt as the Secretary may establish.

SA 57. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Strike section 601.

SA 58. Mr. WEBB (for himself, Mrs. HAGAN, and Mr. SANDERS) submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Beginning on page 271, line 9, strike all through page 273, line 8, and insert the following:

SEC. 700. INCOME OF PARTNERS FOR PERFORMING INVESTMENT MANAGEMENT SERVICES TREATED AS ORDINARY INCOME RECEIVED FOR PERFORMANCE OF SERVICES.

(a) IN GENERAL.—Part I of subchapter K of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 710. SPECIAL RULES FOR PARTNERS PROVIDING INVESTMENT MANAGEMENT SERVICES TO PARTNERSHIP.

''(a) TREATMENT OF DISTRIBUTIVE SHARE OF PARTNERSHIP ITEMS.—For purposes of this title, in the case of an investment services partnership interest—

''(1) IN GENERAL.—Notwithstanding section 702(b)—

''(A) any net income with respect to such interest for any partnership taxable year shall be treated as ordinary income for the performance of services, and

''(B) any net loss with respect to such interest for such year, to the extent not disallowed under paragraph (2) for such year, shall be treated as an ordinary loss.

All items of income, gain, deduction, and loss which are taken into account in computing net income or net loss shall be treated as ordinary income or ordinary loss (as the case may be).

''(2) TREATMENT OF LOSSES.—

''(A) LIMITATION.—Any net loss with respect to such interest shall be allowed for any partnership taxable year only to the extent that such loss does not exceed the excess (if any) of—

''(i) the aggregate net income with respect to such interest for all prior partnership taxable years, over

''(ii) the aggregate net loss with respect to such interest not disallowed under this subparagraph for all prior partnership taxable years.

''(B) CARRYFORWARD.—Any net loss for any partnership taxable year which is not allowed by reason of subparagraph (A) shall be treated as an item of loss with respect to such partnership interest for the succeeding partnership taxable year.

''(C) BASIS ADJUSTMENT.—No adjustment to the basis of a partnership interest shall be made on account of any net loss which is not allowed by reason of subparagraph (A).

''(D) EXCEPTION FOR BASIS ATTRIBUTABLE TO PURCHASE OF A PARTNERSHIP INTEREST.—In the case of an investment services partnership interest acquired by purchase, paragraph (1)(B) shall not apply to so much of any net loss with respect to such interest for any taxable year as does not exceed the excess of—

''(i) the basis of such interest immediately after such purchase, over

''(ii) the aggregate net loss with respect to such interest to which paragraph (1)(B) did not apply by reason of this subparagraph for all prior taxable years.

Any net loss to which paragraph (1)(B) does not apply by reason of this subparagraph shall not be taken into account under subparagraph (A).

''(E) PRIOR PARTNERSHIP YEARS.—Any reference in this paragraph to prior partnership taxable years shall only include prior partnership taxable years to which this section applies.

''(3) NET INCOME AND LOSS.—For purposes of this section—

''(A) NET INCOME.—The term 'net income' means, with respect to any investment services partnership interest, for any partnership taxable year, the excess (if any) of—

''(i) all items of income and gain taken into account by the holder of such interest under section 702 with respect to such interest for such year, over

''(ii) all items of deduction and loss so taken into account.

''(B) NET LOSS.—The term 'net loss' means with respect to such interest for such year, the excess (if any) of the amount described in subparagraph (A)(ii) over the amount described in subparagraph (A)(i).

''(b) DISPOSITIONS OF PARTNERSHIP INTERESTS.—

''(1) GAIN.—Any gain on the disposition of an investment services partnership interest shall be treated as ordinary income for the performance of services.

''(2) LOSS.—Any loss on the disposition of an investment services partnership interest shall be treated as an ordinary loss to the extent of the excess (if any) of—

''(A) the aggregate net income with respect to such interest for all partnership taxable years, over

''(B) the aggregate net loss with respect to such interest allowed under subsection (a)(2) for all partnership taxable years.

''(3) DISPOSITION OF PORTION OF INTEREST.—In the case of any disposition of an investment services partnership interest, the amount of net loss which otherwise would have (but for subsection (a)(2)(C)) applied to reduce the basis of such interest shall be disregarded for purposes of this section for all succeeding partnership taxable years.

''(4) DISTRIBUTIONS OF PARTNERSHIP PROPERTY.—In the case of any distribution of property by a partnership with respect to any investment services partnership interest held by a partner—

''(A) the excess (if any) of—

''(i) the fair market value of such property at the time of such distribution, over

''(ii) the adjusted basis of such property in the hands of the partnership,

shall be taken into account as an increase in such partner's distributive share of the taxable income of the partnership (except to the extent such excess is otherwise taken into account in determining the taxable income of the partnership),

''(B) such property shall be treated for purposes of subpart B of part II as money distributed to such partner in an amount equal to such fair market value, and

''(C) the basis of such property in the hands of such partner shall be such fair market value.

Subsection (b) of section 734 shall be applied without regard to the preceding sentence.

''(5) APPLICATION OF SECTION 751.—In applying section 751(a), an investment services partnership interest shall be treated as an inventory item.

''(c) INVESTMENT SERVICES PARTNERSHIP INTEREST.—For purposes of this section—

''(1) IN GENERAL.—The term 'investment services partnership interest' means any interest in a partnership which is held by any person if such person provides (directly or indirectly) a substantial quantity of any of the following services with respect to the assets of the partnership in the conduct of the trade or business of providing such services:

''(A) Advising as to the advisability of investing in, purchasing, or selling any specified asset.

''(B) Managing, acquiring, or disposing of any specified asset.

''(C) Arranging financing with respect to acquiring specified assets.

''(D) Any activity in support of any service described in subparagraphs (A) through (C).

For purposes of this paragraph, the term 'specified asset' means securities (as defined in section 475(c)(2) without regard to the last sentence thereof), real estate, commodities (as defined in section 475(e)(2))), or options or derivative contracts with respect to securities (as so defined), real estate, or commodities (as so defined).

''(2) EXCEPTION FOR CERTAIN CAPITAL INTERESTS.—

''(A) IN GENERAL.—If—

''(i) a portion of an investment services partnership interest is acquired on account of a contribution of invested capital, and

''(ii) the partnership makes a reasonable allocation of partnership items between the portion of the distributive share that is with respect to invested capital and the portion of such distributive share that is not with respect to invested capital,

then subsection (a) shall not apply to the portion of the distributive share that is with respect to invested capital. An allocation will not be treated as reasonable for purposes of this subparagraph if such allocation would result in the partnership allocating a greater portion of income to invested capital than any other partner not providing services would have been allocated with respect to the same amount of invested capital.

''(B) SPECIAL RULE FOR DISPOSITIONS.—In any case to which subparagraph (A) applies, subsection (b) shall not apply to any gain or loss allocable to invested capital. The portion of any gain or loss attributable to invested capital is the proportion of such gain or loss which is based on the distributive share of gain or loss that would have been allocable to invested capital under subparagraph (A) if the partnership sold all of its assets immediately before the disposition.

''(C) INVESTED CAPITAL.—For purposes of this paragraph, the term 'invested capital' means, the fair market value at the time of contribution of any money or other property contributed to the partnership.

''(D) TREATMENT OF CERTAIN LOANS.—

''(i) PROCEEDS OF PARTNERSHIP LOANS NOT TREATED AS INVESTED CAPITAL OF SERVICE PROVIDING PARTNERS.—For purposes of this paragraph, an investment services partnership interest shall not be treated as acquired

on account of a contribution of invested capital to the extent that such capital is attributable to the proceeds of any loan or other advance made or guaranteed, directly or indirectly, by any partner or the partnership.

''(ii) LOANS FROM NONSERVICE PROVIDING PARTNERS TO THE PARTNERSHIP TREATED AS INVESTED CAPITAL.—For purposes of this paragraph, any loan or other advance to the partnership made or guaranteed, directly or indirectly, by a partner not providing services to the partnership shall be treated as invested capital of such partner and amounts of income and loss treated as allocable to invested capital shall be adjusted accordingly.

''(d) OTHER INCOME AND GAIN IN CONNECTION WITH INVESTMENT MANAGEMENT SERVICES.—

''(1) IN GENERAL.—If—

''(A) a person performs (directly or indirectly) investment management services for any entity,

''(B) such person holds a disqualified interest with respect to such entity, and

''(C) the value of such interest (or payments thereunder) is substantially related to the amount of income or gain (whether or not realized) from the assets with respect to which the investment management services are performed,

any income or gain with respect to such interest shall be treated as ordinary income for the performance of services. Rules similar to the rules of subsection (c)(2) shall apply where such interest was acquired on account of invested capital in such entity.

''(2) DEFINITIONS.—For purposes of this subsection—

''(A) DISQUALIFIED INTEREST.—The term 'disqualified interest' means, with respect to any entity—

''(i) any interest in such entity other than indebtedness,

''(ii) convertible or contingent debt of such entity,

''(iii) any option or other right to acquire property described in clause (i) or (ii), and

''(iv) any derivative instrument entered into (directly or indirectly) with such entity or any investor in such entity.

Such term shall not include a partnership interest and shall not include stock in a taxable corporation.

''(B) TAXABLE CORPORATION.—The term 'taxable corporation' means—

''(i) a domestic C corporation, or

''(ii) a foreign corporation subject to a comprehensive foreign income tax.

''(C) INVESTMENT MANAGEMENT SERVICES.—The term 'investment management services' means a substantial quantity of any of the services described in subsection (c)(1) which are provided in the conduct of the trade or business of providing such services.

''(D) COMPREHENSIVE FOREIGN INCOME TAX.—The term 'comprehensive foreign income tax' means, with respect to any foreign corporation, the income tax of a foreign country if—

''(i) such corporation is eligible for the benefits of a comprehensive income tax treaty between such foreign country and the United States, or

''(ii) such corporation demonstrates to the satisfaction of the Secretary that such foreign country has a comprehensive income tax.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as are necessary or appropriate to carry out the purposes of this section, including regulations to—

''(1) prevent the avoidance of the purposes of this section, and

''(2) coordinate this section with the other provisions of this subchapter.

''(f) CROSS REFERENCE.—For 40 percent no fault penalty on certain underpayments due to the avoidance of this section, see section 6662.''.

(b) APPLICATION TO REAL ESTATE INVESTMENT TRUSTS.—

(1) IN GENERAL.—Subsection (c) of section 856 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(9) EXCEPTION FROM RECHARACTERIZATION OF INCOME FROM INVESTMENT SERVICES PARTNERSHIP INTERESTS.—

''(A) IN GENERAL.—Paragraphs (2), (3), and (4) shall be applied without regard to section 710 (relating to special rules for partners providing investment management services to partnership).

''(B) SPECIAL RULE FOR PARTNERSHIPS OWNED BY REITS.—Section 7704 shall be applied without regard to section 710 in the case of a partnership which meets each of the following requirements:

''(i) Such partnership is treated as publicly traded under section 7704 solely by reason of interests in such partnership being convertible into interests in a real estate investment trust which is publicly traded.

''(ii) 50 percent or more of the capital and profits interests of such partnership are owned, directly or indirectly, at all times during the taxable year by such real estate investment trust (determined with the application of section 267(c)).

''(iii) Such partnership meets the requirements of paragraphs (2), (3), and (4) (applied without regard to section 710).''.

(2) CONFORMING AMENDMENT.—Paragraph (4) of section 7704(d) of such Code is amended by inserting ''(determined without regard to section 856(c)(8))'' after ''856(c)(2)''.

(c) IMPOSITION OF PENALTY ON UNDERPAYMENTS.—

(1) IN GENERAL.—Subsection (b) of section 6662 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (5) the following new paragraph:

''(6) The application of subsection (d) of section 710 or the regulations prescribed under section 710(e) to prevent the avoidance of the purposes of section 710.''.

(2) AMOUNT OF PENALTY.—

(A) IN GENERAL.—Section 6662 of such Code is amended by adding at the end the following new subsection:

''(i) INCREASE IN PENALTY IN CASE OF PROPERTY TRANSFERRED FOR INVESTMENT MANAGEMENT SERVICES.—In the case of any portion of an underpayment to which this section applies by reason of subsection (b)(6), subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent'.''.

(B) CONFORMING AMENDMENTS.—Subparagraph (B) of section 6662A(e)(2) of such Code is amended—

(i) by striking ''section 6662(h)'' and inserting ''subsection (h) or (i) of section 6662'', and

(ii) by striking ''GROSS VALUATION MISSTATEMENT PENALTY'' in the heading and inserting ''CERTAIN INCREASED UNDERPAYMENT PENALTIES''.

(3) REASONABLE CAUSE EXCEPTION NOT APPLICABLE.—Subsection (c) of section 6664 of such Code is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(B) by striking ''paragraph (2)'' in paragraph (4), as so redesignated, and inserting ''paragraph (3)'', and

(C) by inserting after paragraph (1) the following new paragraph:

''(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of an underpayment to which this section applies by reason of subsection (b)(6).''.

(d) CONFORMING AMENDMENTS.—

(1) Subsection (d) of section 731 of the Internal Revenue Code of 1986 is amended by inserting ''section 710(b)(4) (relating to distributions of partnership property),'' before ''section 736''.

(2) Section 741 of such Code is amended by inserting ''or section 710 (relating to special rules for partners providing investment management services to partnership)'' before the period at the end.

(3) Paragraph (13) of section 1402(a) of such Code is amended—

(A) by striking ''other than guaranteed'' and inserting ''other than—

''(A) guaranteed'',

(B) by striking the semicolon at the end and inserting '', and'', and

(C) by adding at the end the following new subparagraph:

''(B) any income treated as ordinary income under section 710 received by an individual who provides investment management services (as defined in section 710(d)(2));''.

(4) Paragraph (12) of section 211(a) of the Social Security Act is amended—

(A) by striking ''other than guaranteed'' and inserting ''other than—

''(A) guaranteed'',

(B) by striking the semicolon at the end and inserting '', and'', and

(C) by adding at the end the following new subparagraph:

''(B) any income treated as ordinary income under section 710 of the Internal Revenue Code of 1986 received by an individual who provides investment management services (as defined in section 710(d)(2) of such Code);''.

(5) The table of sections for part I of subchapter K of chapter 1 of such Code is amended by adding at the end the following new item:

''Sec. 710. Special rules for partners providing investment management services to partnership.''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years ending after January 27, 2009.

(2) PARTNERSHIP TAXABLE YEARS WHICH INCLUDE EFFECTIVE DATE.—In applying section 710(a) of the Internal Revenue Code of 1986 (as added by this section) in the case of any partnership taxable year which includes January 27, 2009, the amount of the net income referred to in such section shall be treated as being the lesser of the net income for the entire partnership taxable year or the net income determined by only taking into account items attributable to the portion of the partnership taxable year which is after such date.

(3) DISPOSITIONS OF PARTNERSHIP INTERESTS.—Section 710(b) of the Internal Revenue Code of 1986 (as added by this section) shall apply to dispositions and distributions after January 27, 2009.

(4) OTHER INCOME AND GAIN IN CONNECTION WITH INVESTMENT MANAGEMENT SERVICES.—Section 710(d) of such Code (as added by this section) shall take effect on January 27, 2009.

(5) PUBLICLY TRADED PARTNERSHIPS.—For purposes of applying section 7704, the amendments made by this section shall apply to taxable years beginning after December 31, 2010.

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 ''$38.05 per thousand'',

(2) by striking ''20.719 percent (18.063 percent on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''39.9 percent'', and

(3) by striking ''$48.75 per thousand ($42.50 per thousand on cigars removed during 2000

or 2001)'' in paragraph (2) and inserting ''30.44 cents per cigar''.

(b) CIGARETTES.—Section 5701(b) of such Code is amended—

(1) by striking ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (1) and inserting ''$38.05 per thousand'', and

(2) by striking ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (2) and inserting ''$79.91 per thousand''.

(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)'' and inserting ''2.38 cents''.

(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)'' and inserting ''4.76 cents''.

(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended—

(1) by striking ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'' in paragraph (1) and inserting ''$1.142 cents'', and

(2) by striking ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)'' in paragraph (2) and inserting ''38.05 cents''.

(f) PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)'' and inserting ''$2.1404 cents''.

(g) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking ''$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)'' and inserting ''$18.73''.

SA 59. Mr. VITTER submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Strike section 114 and insert the following:

SEC. 114. CHIP GROSS INCOME ELIGIBILITY CEILING.

(a) APPLICATION OF CHIP ELIGIBILITY CEILING.—

(1) IN GENERAL.—Section 2110 (42 U.S.C. 1397jj) is amended—

(A) in subsection (b)(1)—

(i) by striking ''and'' at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(D) whose gross family income (as defined in subsection (c)(9)) does not exceed 250 percent of the poverty line.''; and

(B) in subsection (c), by adding at the end the following new paragraph:

''(9) GROSS FAMILY INCOME.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'gross family income' means, with respect to an individual, gross income (as defined by the Secretary in regulations) for the members of the individual's family. For purposes of the previous sentence, in defining 'gross income' the Secretary shall, to the maximum extent practicable, include income from whatever source, other than amounts deducted under section 62(a)(1) of the Internal Revenue Code of 1986.

''(B) INCOME DISREGARDS AUTHORIZED.—A State may provide, through a State plan amendment and with the approval of the Secretary, for the disregard from gross family income of one or more amounts so long as the total amount of such disregards for a family does not exceed $250 per month, or $3,000 per year.''.

(2) DENIAL OF FEDERAL MATCHING PAYMENTS FOR STATE SCHIP EXPENDITURES FOR INDIVIDUALS WITH GROSS FAMILY INCOME ABOVE 250 PERCENT OF THE POVERTY LINE.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) DENIAL OF PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE FOR INDIVIDUALS WHOSE GROSS FAMILY INCOME EXCEEDS 250 PERCENT OF THE POVERTY LINE.—No payment may be made under this section, for any expenditures for providing child health assistance or health benefits coverage under a State child health plan under this title, including under a waiver under section 1115, with respect to an individual whose gross family income (as defined in section 2110(c)(9)) exceeds 250 percent of the poverty line.''.

(b) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section shall apply to payments made for items and services furnished on or after the first day of the first calendar quarter beginning more than 90 days after the date of the enactment of this Act.

(2) TRANSITION.—The amendments made by—

(A) subsection (a)(1) shall not apply to an individual who was receiving, or was determined eligible to receive, child health assistance or health benefits coverage under a State child health plan under title XXI of the Social Security Act, including under a waiver under section 1115 of such Act, as of the day before the date of the enactment of this Act, until such date as the individual is determined ineligible using income standards or methodologies in place as of the day before the date of the enactment of this Act; and

(B) subsection (a)(2) shall not apply to payment for items and services furnished to an individual described in subparagraph (B).

SA 60. Mr. WICKER (for himself and Mr. COCHRAN) submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 76, after line 23, add the following:

SEC. 116. ASSURING COVERAGE OF LOW-INCOME CHILDREN.

Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 601(a)(1), is amended by adding at the end the following new paragraph:

''(12) NO PAYMENTS TO ANY STATE FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE OR HEALTH BENEFITS COVERAGE FOR INDIVIDUALS WHOSE GROSS FAMILY INCOME EXCEEDS 200 PERCENT OF THE POVERTY LINE UNTIL AT LEAST 90 PERCENT OF ALL UNITED STATES ELIGIBLE CHILDREN WHOSE GROSS FAMILY INCOME DOES NOT EXCEED 200 PERCENT OF THE POVERTY LINE ARE ENROLLED IN MEDICAID OR CHIP .—Notwithstanding any other provision of this title or title XIX, for fiscal year quarters beginning on or after January 1, 2009, no payments shall be made to any State under subsection (a)(1) or section 1903(a) on the basis of the enhanced FMAP for providing child health assistance or health benefits coverage for any individual whose gross family income (as defined by the Secretary) exceeds 200 percent of the poverty line for any fiscal year quarter that begins before the date on which the Secretary certifies to Congress that at least 90 percent of all children in the United States whose gross family income (as so defined) does not exceed 200 percent of the poverty line, and who are eligible for child health assistance under a State child health plan under this title or for medical assistance under a State plan under title XIX (or under a waiver of such plans), are enrolled in such plans.''.

SA 61. Mr. BINGAMAN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 130, strike lines 8 through 13, and insert the following:

(d) APPLICABILITY; GENERAL EFFECTIVE DATE.—

(1) CONDITION FOR APPLICATION.—

(A) IN GENERAL.—

(i) GENERAL EFFECTIVE DATE.—Subject to clause (ii), except as provided in subparagraph (B), the amendments made by this section shall take effect on January 1, 2010.

(ii) CERTIFICATION REQUIREMENT.—Notwithstanding any other provision of law, no State with a State plan under Medicaid or a State child health plan under CHIP shall be required to comply with section 1902(a)(46)(B) or 2105(c)(9) of the Social Security Act before the date on which the Secretary and the Commissioner of Social Security jointly certify that a significant number of United States citizens, including citizen children, who are eligible for coverage under such plans will not lose that coverage as a result of the application of such requirements. For purposes of the preceding sentence, the Secretary and the Commissioner of Social Security shall determine what is a significant number of such citizens on the basis of the best estimates available of the number of non-citizens that the application of such requirements may prevent from fraudulently obtaining assistance under such plans, compared to the best estimates available of the number of United States citizens that may be inappropriately disenrolled from, or prevented from enrolling in, such plans as a result of the application of such requirements.

(iii) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(I) IN GENERAL.—

(aa) in clause (xi), by striking ''and'' at the end;

(bb) in clause (xii), by striking the period at the end and inserting ''; and''; and

(cc) by adding at the end the following:

''(xiii) such contract provides that (I) payment for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall allow the entity to collect such rebates from manufacturers, and (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.''.

(II) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(aa) in subsection (d)—

(AA) in paragraph (1), by adding at the end the following:

''(C) Notwithstanding the subparagraphs (A) and (B)—

''(i) a medicaid managed care organization with a contract under section 1903(m) may exclude or otherwise restrict coverage of a covered outpatient drug on the basis of policies or practices of the organization, such as

those affecting utilization management, formulary adherence, and cost sharing or dispute resolution, in lieu of any State policies or practices relating to the exclusion or restriction of coverage of such drugs; and

''(ii) nothing in this section or paragraph (2)(A)(xiii) of section 1903(m) shall be construed as requiring a medicaid managed care organization with a contract under such section to maintain the same such polices and practices as those established by the State for purposes of individuals who receive medical assistance for covered outpatient drugs on a fee-for service basis.''; and

(bb) in paragraph (4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(cc) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatients drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by a health maintenance organization other than a medicaid managed care organization with a contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(III) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

(iv) INCREASED FUNDING FOR THE MEDICAID IMPROVEMENT FUND.—[*Review with CBO to specify numbers and whether savings all go to 2014 or also to 2015 through 2018*]Section 1941(b)(1)(A) (42 U.S.C. 1936w–1(b)(1)(A)) is amended by striking ''$100,000,000'' and inserting ''$_____''.

SA 62. Mr. BINGAMAN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 108, between lines 3 and 4, insert the following:

''(H) STATE OPTION TO RELY ON STATE INCOME TAX DATA OR RETURN.—At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.''.

SA 63. Mr. BINGAMAN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 99, beginning on line 8 strike ''through'' and all that follows through ''application,'' on line 10, and insert ''in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary and''.

On page 108, between lines 3 and 4, insert the following:

''(H) STATE OPTION TO RELY ON STATE INCOME TAX DATA OR RETURN.—At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.''.

SA 64. Mr. BINGAMAN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 99, beginning on line 8 strike ''through'' and all that follows through ''application,'' on line 10, and insert ''in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary and''.

SA 65. Mr. MARTINEZ (for himself, Mr. VITTER, Mr. WICKER, Mr. BUNNING, Mr. ENZI, Mr. COBURN, Mr. JOHANNS, Mr. BROWNBACK, Mr. INHOFE, Mr. CHAMBLISS, and Mr. DEMINT) submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. RESTORATION OF PROHIBITION ON FUNDING OF NONGOVERNMENTAL ORGANIZATIONS THAT PROMOTE ABORTION AS A METHOD OF BIRTH CONTROL (''MEXICO CITY POLICY'').

Notwithstanding any other provision of law, regulation, or policy, including the memorandum issued by the President on January 23, 2009, to the Administrator of the United States Agency for International Development, titled ''Mexico City Policy and Assistance for Voluntary Family Planning,'' no funds authorized under part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) for population planning activities or other population or family planning assistance may be made available for any private, nongovernmental, or multilateral organization that performs or actively promotes abortion as a method of birth control.

SA 66. Mr. CORNYN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Strike section 114 and insert the following:

SEC. 114. DENIAL OF PAYMENTS FOR COVERAGE OF CHILDREN WITH EFFECTIVE FAMILY INCOME THAT EXCEEDS 200 PERCENT OF THE POVERTY LINE.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) DENIAL OF PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE FOR CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 200 PERCENT OF THE POVERTY LINE.—For child health assistance furnished after the date of the enactment of this paragraph, no payment shall be made under this section for any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose family income (as determined without regard to the application of any general exclusion or disregard of a block of income that is not determined by type of expense or type of income (regardless of whether such an exclusion or disregard is permitted under section 1902(r))) would exceed 200 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.''.

(b) GRANTS TO STATES.—

(1) IN GENERAL.—From amounts appropriated under paragraph (2), the Secretary shall make grants to States as follows:

(A) 75 percent of such amounts shall be directed toward increasing coverage for low-income children under CHIP.

(B) 25 percent of such amounts shall be directed toward activities assisting States, especially States with a high percentage of eligible, but not enrolled children, in outreach and enrollment activities under CHIP, such as—

(i) improving and simplifying enrollment systems, including—

(I) increasing staffing and computer systems to meet Federal and State standards;

(II) decreasing turn-around time while maintaining program integrity; and

(ii) improving outreach and application assistance, including—

(I) connecting children with a medical home and keeping them healthy;

(II) developing systems to identify, inform, and fix enrollment system problems;

(III) supporting awareness of, and access to, other critical health programs;

(IV) pursuing new performance goals to cut ''procedural denials'' to the lowest possible level; and

(V) coordinating community- and school-based outreach programs.

(2) FUNDING.—There is appropriated to provide grants under paragraph (1) an amount equal to the amount of Federal funds that the Director of the Congressional Budget Office certifies would have been expended for the period beginning April 1, 2009, and ending September 30, 2013, if section 114 (relating to limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line) of S. 275 (111th Congress) as reported by the Committee on Finance of the Senate and placed on the Senate calendar on January 16, 2009, had been enacted.

SA 67. Mr. CORNYN submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 45, between lines 17 and 18, insert the following:

''(3) LIMITATION.—

''(A) IN GENERAL.—A State shall not be a shortfall State described in paragraph (2) if the State provides coverage under this title to children whose family income (as determined without regard to the application of any general exclusion or disregard of a block of income that is not determined by type of expense or type of income (regardless of whether such an exclusion or disregard is permitted under section 1902(r))) exceeds 200 percent of the poverty line.

''(B) GRANTS TO STATES WITH UNSPENT FUNDS.—Of any funds that are not redistributed under this subsection because of the application of subparagraph (A), the Secretary shall make grants to States as follows:

''(i) 75 percent of such funds shall be directed toward increasing coverage under this title for low-income children.

''(ii) 25 percent of such funds shall be directed toward activities assisting States, especially States with a high percentage of eligible, but not enrolled children, in outreach and enrollment activities under this title, such as—

''(I) improving and simplifying enrollment systems, including—

''(aa) increasing staffing and computer systems to meet Federal and State standards;

''(bb) decreasing turn-around time while maintaining program integrity; and

''(II) improving outreach and application assistance, including—

''(aa) connecting children with a medical home and keeping them healthy;

''(bb) developing systems to identify, inform, and fix enrollment system problems;

''(cc) supporting awareness of, and access to, other critical health programs;

''(dd) pursuing new performance goals to cut 'procedural denials' to the lowest possible level; and

''(ee) coordinating community- and school-based outreach programs.''.

SA 68. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 75, beginning on line 13, strike ''whose'' and all that follows through line 17, and insert the following: ''whose family income would exceed 300 percent of the poverty line (determined without regard to any block or other income disregard and without excluding any type of expense (regardless, in the case of child health assistance or health benefits coverage provided in the form of coverage under a Medicaid program under paragraph (2) of section 2101(a) (or a combination of the coverage options under paragraphs (1) and (2) of such section) of whether such a disregard or exclusion is permitted under section 1902(r)).''.

SA 69. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Beginning on page 75, strike line 18 and all that follows through page 76, line 2.

SA 70. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Strike section 114 and insert the following:

SEC. 114. DENIAL OF PAYMENTS FOR COVERAGE OF CHILDREN WITH EFFECTIVE FAMILY INCOME THAT EXCEEDS 300 PERCENT OF THE POVERTY LINE.

Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) DENIAL OF PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE FOR CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—For child health assistance furnished after the date of the enactment of this paragraph, no payment shall be made under this section for any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.''.

SA 71. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''SCHIP Funding Extension Act of 2009''.

SEC. 2. FUNDING THROUGH FISCAL YEAR 2010.

(a) THROUGH FISCAL YEAR 2010.—

(1) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd(a)), as amended by section 201(a)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended—

(A) in subsection (a)(11), by striking ''and 2009'' and inserting ''through 2010''; and

(B) in subsection (c)(4)(B), by striking ''2009'' and inserting ''2010''.

(2) AVAILABILITY OF EXTENDED FUNDING.—Funds made available from any allotment made from funds appropriated under subsection (a)(11) or (c)(4)(B) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal year 2009 or 2010 shall not be available for child health assistance for items and services furnished after September 30, 2010.

(b) ADDITIONAL ALLOTMENTS TO MAINTAIN SCHIP PROGRAMS THROUGH FISCAL YEAR 2010.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by striking subsection (l) and inserting the following new subsections:

''(l) ADDITIONAL ALLOTMENTS TO MAINTAIN SCHIP PROGRAMS FOR FISCAL YEAR 2009.—

''(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $3,000,000,000 for fiscal year 2009.

''(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary, that the Federal share amount of the projected expenditures under such plan for such State for fiscal year 2009 will exceed the sum of—

''(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that will not be expended by the end of fiscal year 2008;

''(B) the amount, if any, that is to be redistributed to the State during fiscal year 2009 in accordance with subsection (f); and

''(C) the amount of the State's allotment for fiscal year 2009.

''(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2009, the Secretary shall allot—

''(A) to each shortfall State described in paragraph (2) not described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

''(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

''(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

''(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2008, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

''(6) ONE-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2009, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2009. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

''(m) ADDITIONAL ALLOTMENTS TO MAINTAIN SCHIP PROGRAMS FOR FISCAL YEAR 2010.—

''(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $4,000,000,000 for fiscal year 2010.

''(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary, that the Federal share amount of the projected expenditures under such plan for such State for fiscal year 2010 will exceed the sum of—

''(A) the amount of the State's allotments for each of fiscal years 2008 and 2009 that will not be expended by the end of fiscal year 2009;

''(B) the amount, if any, that is to be redistributed to the State during fiscal year 2010 in accordance with subsection (f); and

''(C) the amount of the State's allotment for fiscal year 2010.

''(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2010, the Secretary shall allot—

''(A) to each shortfall State described in paragraph (2) not described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

''(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

''(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts

computed under such subparagraphs shall be reduced proportionally.

''(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2010, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

''(6) AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2010, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2010. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).''.

(c) EXTENSION OF TREATMENT OF QUALIFYING STATES.—

(1) IN GENERAL.—Section 2105(g)(1)(A) of the Social Security Act (42 U.S.C. 1397ee(g)(1)(A)) is amended by striking ''or 2009'' and inserting ''2009, or 2010''.

(2) APPLICABILITY.—The amendment made by paragraph (1) shall be in effect through September 30, 2010.

(3) REPEAL OF LIMITATION ON AVAILABILITY OF FISCAL YEAR 2009 ALLOTMENTS.—Paragraph (2) of section 201(b) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) is repealed.

SA 72. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

On page 153, between lines 12 and 13, insert the following:

(d) REQUIREMENT FOR STATES COVERING CHILDREN WHOSE INCOME EXCEEDS 200 PERCENT OF THE POVERTY LINE TO OFFER PREMIUM ASSISTANCE FOR ALL FAMILIES OF TARGETED LOW-INCOME CHILDREN.—

(1) IN GENERAL.—Section 2102(a) (42 U.S.C. 1397b(a)) is amended—

(A) in paragraph (6), by striking ''and'' at the end;

(B) in paragraph (7), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(8) effective for plan years beginning on or after October 1, 2009, in the case of a State that provides child health assistance for any targeted low-income child with a family gross income (determined without regard to any block or other income disregard and without excluding any type of expense (regardless, in the case of child health assistance or health benefits coverage provided in the form of coverage under a Medicaid program under paragraph (2) of section 2101(a) (or a combination of the coverage options under paragraphs (1) and (2) of such section) of whether such a disregard or exclusion is permitted under section 1902(r))) that exceeds 200 percent of the poverty line, how the plan shall offer child health assistance in the form of premium assistance to all targeted low-income children who have access to private health insurance coverage or coverage under a group health plan.''.

SA 73. Mr. GRASSLEY submitted an amendment intended to be proposed by him to 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; which was ordered to lie on the table; as follows:

Beginning on page 58, strike line 14 and all that follows through page 62, line 17, and insert the following:

''(a) TERMINATION OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

''(1) NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH 2009.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

''(A) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2009, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

''(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraph (2) shall apply for purposes of any period beginning on the first day of the first month that begins after the 6-month termination period, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

''(2) TERMINATION OF CHIP COVERAGE UNDER APPLICABLE EXISTING WAIVERS 6 MONTHS AFTER THE DATE OF THE ENACTMENT OF THIS ACT.—

''(A) IN GENERAL.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after the last day of the 6-month termination period.

''(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before the date described in paragraph (1)(A), notwithstanding the requirements of subsections (e) and (f) of section 1115, a State may submit, not later than 30 days after the date of enactment of this Act, a request to the Secretary for an extension of the waiver. The Secretary shall approve a request for an extension of an applicable existing waiver submitted pursuant to this subparagraph, but only through the last day of the 6-month termination period.

''(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during the 6-month termination period.

''(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 90 days after the date of enactment of this Act, an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a nonpregnant childless adult whose coverage is so terminated (in this subsection referred to as a ''Medicaid nonpregnant childless adults waiver'').

''(B) DEADLINE FOR APPROVAL.—The Secretary shall make a decision to approve or deny an application for a Medicaid nonpregnant childless adults waiver submitted under subparagraph (A) within 90 days of the date of the submission of the application. If no decision has been made by the Secretary as of the last day of the 6-month termination period, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by the date described in subparagraph (A), the application shall be deemed approved.

''(C) STANDARD FOR BUDGET NEUTRALITY.—The budget neutrality requirement applicable with respect to expenditures for medical assistance under a Medicaid nonpregnant childless adults waiver shall—

''(i) in the case of any period of fiscal year 2009 in which such waiver is in effect, allow expenditures for medical assistance under title XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (2)(B) for any previous corresponding period in fiscal year 2009, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2009 over 2008, as most recently published by the Secretary;

''(ii) in the case of fiscal year 2010, allow expenditures for medical assistance under title XIX for all such adults to not exceed the sum of the total amount of payments made to the State under paragraph (2)(B) for fiscal year 2009 and under title XIX for any period of fiscal year 2009 in which such waiver is in effect, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as most recently published by the Secretary; and

''(iii) 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.

''(4) 6-MONTH TERMINATION PERIOD.—In this subsection, the term ''6-month termination period'' means the period that begins with the first day of the first month that begins on or after the date of enactment of this Act and ends on the last day of the 5th succeeding month.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. CASEY. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Tuesday, January 27, 2009, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. CASEY. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on January 27, 2009 at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. CASEY. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Tuesday, January 27, 2009, at 10:30 a.m., in room 215 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. CASEY. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet, during the session of the Senate, conduct a hearing entitled ''Access to Prevention and Public Health for High Risk Populations'' on Tuesday, January 27, 2009. The hearing will commence at 10 a.m. in room 385 of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate Committee on the Judiciary be authorized to meet during the session of the Senate, to conduct a hearing entitled ''Health IT: Protecting Americans' Privacy in the Digital Age'' on Tuesday, January 27, 2009, at 9:30 a.m., in room SD–226 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. HATCH. I ask unanimous consent that Dr. Janet Phoenix, my health policy fellow, be granted the privilege of the floor during Senate consideration of H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. COBURN. Mr. President, I ask unanimous consent that Stephanie Carlton and Evan Feinberg of my staff be granted the privilege of the floor during debate on H.R. 2.

The PRESIDING OFFICER. Without objection, it is so ordered.

CATHOLIC SCHOOLS WEEK

Mr. DURBIN. I ask unanimous consent the Senate now proceed to consideration of S. Res. 22, which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 22) recognizing the goals of Catholic Schools Week and honoring the valuable contributions of Catholic schools in the United States.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. I ask unanimous consent the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid on the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 22) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 22

Whereas Catholic schools in the United States have received international acclaim for academic excellence while providing students with lessons that extend far beyond the classroom;

Whereas Catholic schools present a broad curriculum that emphasizes the lifelong development of moral, intellectual, physical, and social values in the young people of the United States;

Whereas Catholic schools in the United States today educate 2,270,913 students and maintain a student-to-teacher ratio of 14 to 1;

Whereas the faculty members of Catholic schools teach a highly diverse body of students;

Whereas the graduation rate for all Catholic school students is 95 percent;

Whereas 83 percent of Catholic high school graduates go on to college;

Whereas Catholic schools produce students strongly dedicated to their faith, values, families, and communities by providing an intellectually stimulating environment rich in spiritual character and moral development; and

Whereas in the 1972 pastoral message concerning Catholic education, the National Conference of Catholic Bishops stated, ''Education is one of the most important ways by which the Church fulfills its commitment to the dignity of the person and building of community. Community is central to education ministry, both as a necessary condition and an ardently desired goal. The educational efforts of the Church, therefore, must be directed to forming persons-in-community; for the education of the individual Christian is important not only to his solitary destiny, but also the destinies of the many communities in which he lives.'': Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the goals of Catholic Schools Week, an event cosponsored by the National Catholic Educational Association and the United States Conference of Catholic Bishops that recognizes the vital contributions of thousands of Catholic elementary and secondary schools in the United States; and

(2) commends Catholic schools, students, parents, and teachers across the United States for their ongoing contributions to education, and for the vital role they play in promoting and ensuring a brighter, stronger future for the United States.

HONORING THE LIFE OF ANDREW WYETH

Mr. DURBIN. Mr. President, I ask unanimous consent the Senate proceed to the immediate consideration of S. Res. 23, submitted earlier today by Senator CASEY.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 23) honoring the life of Andrew Wyeth.

There being no objection, the Senate proceeded to consider the resolution.

Ms. SNOWE. Mr. President, I rise as a cosponsor of Senator SPECTER's resolution honoring Andrew Wyeth and to pay tribute to the landmark life and legacy of this towering giant of American Art. My State of Maine joins Pennsylvania, the Nation, and the world in mourning the inexpressible loss of Andrew Wyeth, a painter of enormous genius, brave vision, and unmatched realism who long ago secured a rightful and prominent place in the pantheon of artists.

One of the most 'American' of painters, Andrew Wyeth possessed a courage and sensitivity to capture the stark beauty of the landscapes and individuals he depicted. And those of us from Maine will forever hold a special place in our hearts for the undeniable love he had for our State, as portrayed in his moving landscapes of Maine's coasts and especially in his exceptional ''Christina's World.'' Like millions around the world, we will miss Andrew Wyeth's historic and enduring contributions to the American story as told on canvas as well as his powerful capacity for capturing the human condition unvarnished.

On a personal note, it was such a privilege to know Andy and his wonderful wife, Betsy, over the years. I will always treasure the fond memories of visiting Andy and Betsy and their family at their home on Allen Island. Indisputably, Andy lived his life the way he painted—with integrity, grace, and an abiding sense of humanity. And I always remember the pride and honor I felt attending the presentation of a National Medal of the Arts in 2007 to Andy at the White House in an unforgettable ceremony rightly recognizing his iconic body of work over an extraordinary lifetime.

I would like to include for the RECORD a recent outstanding article entitled Wyeth's White Wonder by John Wilmerding, published in The Wall Street Journal, Saturday, January 24, 2009. Formerly a professor at Dartmouth College, Mr. Wilmerding curated the exhibition Andrew Wyeth: The Helga Pictures at the National Gallery of Art in 1987 and recently retired as Sarofim Professor of American Art at Princeton University. Describing Andrew Wyeth's Snow Hill as one of his most memorable works, Mr. Wilmerding captures the essence of the painting and the painter, calling Snow Hill ''one of the most haunting, beautiful and resonant of Wyeth's seven-decade career.''

Poet Robert Frost once wrote of a star that ''it asks a little of us here/It asks of us a certain height,'' and certainly the same can be said of Andrew Wyeth who inspired and entreated us to experience his courageous rendering of the world as he saw it, and like generations to come, we are eternally indebted to him. Andrew Wyeth's artistic achievements resonate not only in our time—but for all time. He will be profoundly missed, and we extend our deepest condolences to Betsy and to our great friends—their son, Jamie and his wife, Phyllis—their son, Nicholas; and the entire Wyeth family for their tremendous loss.

I ask unanimous consent the article be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, Jan. 24–25, 2009]

WYETH'S WHITE WONDER

(By John Wilmerding)

Andrew Wyeth died last week on a winter's day familiar to us from many of his paintings: snowy, cold and moody. Perhaps the best form of appreciation we can express for his artistic achievement is to undertake a close look at one of his iconic works in this case ''Snow Hill,'' a painting from the height of his powers that is relatively little known, seen or reproduced. While it has been on loan to the Brandywine Museum (www.brandywine-museum.org) for several years, its fragility of surface has kept it from going out on loan to a wider audience, and its singularity of subject matter has not readily found it a place in recent Wyeth monographs or exhibition catalogs. Only posterity is likely to sort out which of his paintings will stand up as his most memorable works, but ''Snow Hill'' is likely to hold its own as one of the most haunting, beautiful and resonant of Wyeth's seven-decade career.

Indeed, the picture is about marking seven decades. Wyeth, who lived to the age of 91, painted this large tempera to mark his 70th birthday (in 1987). He finished the painstaking effort two years later. There are few others that are larger and as ambitious. The artist was conscious of mortality for much of his career, from the deaths of his father and nephew in a train accident in 1945, to his own miscellaneous ailments, operations and illnesses throughout his later years.

We know that many of his images were in varying degrees autobiographical, and this painting was a conscious summary of his artistic life that was both somber memoir and playful recalibraion. Like many of Wyeth's winter landscapes in watercolor, dry-brush, or egg tempera, this makes the most of a near-monochromatic palette, where darks and lights play against each other, and nature's full range of grays and tans takes on a heightened texture. One of his great talents was an intense technical virtuosity in all of his chosen media. Yet even as his admirers and critics are drawn to the magic realism of objects and surfaces, it is the charged emotion, suggestive meaning, and complex moods beneath facades and faces that distinguish his finest visions.

The setting was intimately familiar to Wyeth almost his entire life, a view looking down over the Kuerner farm and the nearby hills of the Brandywine Valley in Pennsylvania. The artist knew almost every inch of the roads, buildings and fields we see in the distance below. Historians and others may argue for some time whether his future reputation will rest on the landscapes or portraits (respectively descended from two of his artistic idols, Winslow Homer and Thomas Eakins). ''Snow Hill'' is unusual in the merging of the two—one open, silent and vast; the other intimate, animate and active. The foreground hilltop, receding valley, and broad sky constitute a painted tour de force of whites, off-whites and cream colors. Its poetic emptiness recalls the stark eloquence seen in but a few of Wyeth's other strongest compositions—such as ''Christina's World'' (1949), ''River Cove'' (1958) and ''Airborne'' (1996).

Atop the hillside we view the improbable scene of a Maypole dance at Christmas time. The seven ribbons descending from beneath the tree above mark the artist's seven decades. In a surreal vision, Wyeth assembles prominent figures from his life and art who appeared in major paintings over the years. Holding hands from left to right across the foreground are Karl and Anna Kuerner, followed by William Loper and Helga Testorf. In the back right is the family friend and neighbor Allan Lynch, wearing his telltale hat with earflaps flying, and finally, partially obscured, a figure with billowing brown coat who recalls the artist's wife, Betsy, posing years earlier in the snowy courtyard of their Chadd's Ford farmhouse. In this enumeration we realize the group only comes to six, suggesting a missing seventh figure. Possibly Christina Olson, the most enduring of Wyeth's Maine subjects, made famous by his first masterpiece, ''Christina's World,'' is not present, since her paralysis would keep her from dancing. Or perhaps the implied seventh individual might be the artist himself, participant in their lives and unseen orchestrator of this imaginary get-together. In any case, this is a witty and exuberant conjuring of artistic imagination.

Not surprisingly for Wyeth, however, there are notes of darkness beneath the celebratory gathering: Wyeth had lived through Karl Kuerner succumbing to cancer, Allan Lynch to suicide, and William Loper to madness. Even so, what we ultimately experience here is the enjoyment of art, life and creativity, an idea subtly but vividly conveyed by the air-touched ribbons. They contain the most intense colors and free-flowing brushstrokes in this picture. Wyeth once described how he approached their execution. In part remembering his childhood games with friends, dressing up as soldiers or medieval knights with play swords or sabers, he envisioned here addressing the painting like a fencer with an epee. With arm and brush extended, he swiftly moved to the surface and slashed each stroke of color from the apex down to the figures.

There is one more level of meaning embodied in this half-real, half-dream image, which resides in its title. ''Snow Hill'' is at once a literal description and a literary allusion. Yes, our vantage point is on the crown of this snowy hill, gently curving across the foreground. But its contour also brings to mind the great rounded back of a white whale, which Wyeth connected to ''Moby-Dick.'' His painting's title comes from a line toward the end of Melville's book. In chapter 133, ''The Chase—First Day,'' a sailor aloft cries, ''there she blows!—there she blows! A hump like a snow-hill! It is Moby Dick!'' This of course reinforces Wyeth's own juxtapositions of black and white, darkness and light, death and life. His ''Snow Hill'' is a more personal drama than Melville's, but no less a celebration of whiteness, in symbolism and pigment.

Mr. DURBIN. I ask unanimous consent the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res 23) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 23

Whereas Andrew Wyeth was one of the most popular American artists of the twentieth century, whose paintings presented to the world his impressions of rural American landscapes and lives;

Whereas Andrew Wyeth was born in Chadds Ford, Pennsylvania on July 12, 1917, where he spent much of his life and where today stands the Brandywine River Museum, a museum dedicated to the works of the Wyeth family;

Whereas Andrew Wyeth died the morning of January 16, 2009, at the age of 91, in his home in Chadds Ford, Pennsylvania;

Whereas it is the intent of the Senate to recognize and pay tribute to the life of Andrew Wyeth, his passion for painting, his contribution to the world of art, and his deep understanding of the human condition;

Whereas Andrew Wyeth was born the son of famed illustrator N.C. Wyeth and grew up surrounded by artists in an environment that encouraged imagination and free-thinking;

Whereas Andrew Wyeth became an icon who focused his work on family and friends in Chadds Ford and in coastal Maine, where he spent his summers and where he met Christina Olson, the subject of his famed painting 'Christina's World';

Whereas Andrew Wyeth's paintings were immensely popular among the public but sometimes disparaged by critics for their lack of color and bleak landscapes portraying isolation and alienation;

Whereas Andrew Wyeth's works could be controversial, as they sparked dialogue and disagreement in the art world concerning the natures of realism and modernism;

Whereas Andrew Wyeth was immensely patriotic and an independent thinker who broke with many of his peers on the issues of the day;

Whereas Andrew Wyeth was a beloved figure in Chadds Ford and had his own seat at the corner table of the Chadds Ford Inn, where reproductions of his art line the walls;

Whereas Andrew Wyeth received the Presidential Medal of Freedom in 1963 and the Congressional Gold Medal of Honor in 1988;

Whereas Andrew Wyeth let it be known that he lived to paint and never lost his simplicity and caring for people despite his immense fame and successful career; and

Whereas the passing of Andrew Wyeth is a great loss to the world of art, and his life should be honored with highest praise and appreciation for his paintings which remain with us although he is gone: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes Andrew Wyeth as a treasure of the United States and one of the most popular artists of the twentieth century; and

(2) recognizes the outstanding contributions of Andrew Wyeth to the art world and to the community of Chadds Ford, Pennsylvania.

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the Vice President, pursuant to 22 U.S.C. 276h–276k, as amended, appoints the following Senator as Chairman to the Mexico-U.S. Interparliamentary Group conference for the 111th Congress: The Honorable CHRISTOPHER J. DODD of Connecticut.

ORDERS FOR WEDNESDAY, JANUARY 28, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, the Senate stand in adjournment until 10 a.m. tomorrow, Wednesday, January 28; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 2, the Children's

Health Insurance Program Reauthorization Act.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. DURBIN. Mr. President, tomorrow the Senate will resume consideration of the children's health insurance bill. We will continue to work through the amendments to the bill.

I want to say, by way of observation, that today's proceedings in the Senate were refreshing and positive. Amendments were brought to the floor, debated, voted on, and we are moving on to more tomorrow. It is almost like the Senate of old.

We will continue to work through amendments to the bill, and I hope in the spirit of bipartisan cooperation we can complete this bill. Senators should be prepared to work on these amendments and vote throughout the day tomorrow.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. DURBIN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that it stand adjourned under the previous order.

There being no objection, the Senate, at 7:22 p.m., adjourned until Wednesday, January 28, 2009, at 10 a.m.

NOMINATIONS

Executive nomination received by the Senate:

INTERNATIONAL BANKS

TIMOTHY F. GEITHNER, OF NEW YORK, TO BE UNITED STATES GOVERNOR OF THE INTERNATIONAL MONETARY FUND FOR A TERM OF FIVE YEARS; UNITED STATES GOVERNOR OF THE INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT FOR A TERM OF FIVE YEARS; UNITED STATES GOVERNOR OF THE INTER-AMERICAN DEVELOPMENT BANK FOR A TERM OF FIVE YEARS; UNITED STATES GOVERNOR OF THE AFRICAN DEVELOPMENT BANK FOR A TERM OF FIVE YEARS; UNITED STATES GOVERNOR OF THE ASIAN DEVELOPMENT BANK; UNITED STATES GOVERNOR OF THE AFRICAN DEVELOPMENT FUND; UNITED STATES GOVERNOR OF THE EUROPEAN BANK FOR RECONSTRUCTION AND DEVELOPMENT, VICE HENRY M. PAULSON JR., RESIGNED.

DISCHARGED NOMINATION

The Senate Committee on Banking, Housing, and Urban Affairs was discharged from further consideration of the following nomination by unanimous consent and the nomination was confirmed:

DANIEL K. TARULLO, OF MASSACHUSETTS, TO BE A MEMBER OF THE BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM FOR A TERM OF FOURTEEN YEARS FROM FEBRUARY 1, 2008.

CONFIRMATION

Executive nomination confirmed by the Senate Tuesday, January 27, 2009:

FEDERAL RESERVE SYSTEM

DANIEL K. TARULLO, OF MASSACHUSETTS, TO BE A MEMBER OF THE BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM FOR A TERM OF FOURTEEN YEARS FROM FEBRUARY 1, 2008.