

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.

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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. JOHANNES, 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 esti-

mated by the Secretary) for the year in which such subsequent fiscal year ends.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(D) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—For purposes of subparagraph (B), the projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average

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

“(E) AMOUNTS AVAILABLE FOR PAYMENTS.—

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

“(ii) TRANSFERS.—Notwithstanding any other provision of this title, the following amounts shall also be available, without fiscal year limitation, for making payments under this paragraph:

“(I) UNOBLIGATED NATIONAL ALLOTMENT.—

“(aa) FISCAL YEARS 2009 THROUGH 2012.—As of December 31 of fiscal year 2009, and as of December 31 of each succeeding fiscal year through fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.

“(bb) FIRST HALF OF FISCAL YEAR 2013.—As of December 31 of fiscal year 2013, the portion, if any, of the sum of the amounts appropriated under subsection (a)(16)(A) and under section 108 of the Children’s Health Insurance Reauthorization Act of 2009 for the period beginning on October 1, 2012, and ending on March 31, 2013, that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

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

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

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

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

“(iii) PROPORTIONAL REDUCTION.—If the sum of the amounts otherwise payable under this paragraph for a fiscal year exceeds the

amount available for the fiscal year under this subparagraph, the amount to be paid under this paragraph to each State shall be reduced proportionally.

“(F) QUALIFYING CHILDREN DEFINED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

for purposes of determining and redetermining financial eligibility; and

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

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

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

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

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

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

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

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

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

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

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

“(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

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

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

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

“(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of

the fiscal year in which they are redistributed.”.

SEC. 106. REDISTRIBUTION OF UNUSED ALLOTMENTS.

(a) BEGINNING WITH FISCAL YEAR 2007.—

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

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

“(1) IN GENERAL.—The Secretary”;

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

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

“(2) SHORTFALL STATES DESCRIBED.—

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

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

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

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

“(B) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally.

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

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

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

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

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

(3) in paragraph (6)—

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

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

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

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

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

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

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

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

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

“(A) PAYMENT OF ENHANCED PORTION OF MATCHING RATE FOR CERTAIN EXPENDITURES.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State’s allotment made under section 2104 for any of fiscal years 2009 through 2013 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

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

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

SEC. 108. ONE-TIME APPROPRIATION.

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

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

Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

“(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal years beginning with fiscal year 2009, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), and (3) of this subsection) to such commonwealth or territory for such fiscal year.”.

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

SEC. 111. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN UNDER CHIP THROUGH A STATE PLAN AMENDMENT.

(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 112(a), is amended by adding at the end the following new section:

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

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

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

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

“(A) for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (1)(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 (1)(1)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.

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

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

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

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

“(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the

enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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

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

“(1) **PREGNANCY-RELATED ASSISTANCE.**—The term ‘pregnancy-related assistance’ has the meaning given the term ‘child health assistance’ in section 2110(a) with respect to an individual during the period described in paragraph (2)(A).

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

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

“(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

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

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

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

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

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

“(B) pregnancy-related services through the application of any waiver authority (as in effect on June 1, 2008).

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

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

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

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

(b) **ADDITIONAL CONFORMING AMENDMENTS.**—

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

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

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

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

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

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

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

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

SEC. 112. PHASE-OUT OF COVERAGE FOR NON-PREGNANT CHILDLESS ADULTS UNDER CHIP; CONDITIONS FOR COVERAGE OF PARENTS.

(a) **PHASE-OUT RULES.**—

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

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

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

“(1) **NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH 2009.**—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

“(A) the Secretary shall not on or after the date of the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

“(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraph (2) shall apply for purposes of any period beginning on or after January 1, 2010, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

“(2) **TERMINATION OF CHIP COVERAGE UNDER APPLICABLE EXISTING WAIVERS AT THE END OF 2009.**—

“(A) **IN GENERAL.**—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after December 31, 2009.

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

“(C) **APPLICATION OF ENHANCED FMAP.**—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during the period beginning on the date of the enactment of this subsection and ending on December 31, 2009.

“(3) **STATE OPTION TO APPLY FOR MEDICAID WAIVER TO CONTINUE COVERAGE FOR NON-PREGNANT 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 inter-agency 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 eligi-

bility 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)”; and

(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 submission 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 non-discriminatory 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 non-discriminatory 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 contact 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 multi-sectoral, 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(1)(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 SPECIALTY SERVICES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including—

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

(B) information on such children's access to networks of care;

(C) geographic availability of primary and specialty services under such programs;

(D) the extent to which care coordination is provided for children's care under Medicaid and CHIP; and

(E) as appropriate, information on the degree of availability of services for children under such programs.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the 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)(i) 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)(i) 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”;

(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”;

(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”;

(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 any 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.

(1) **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, ciga-

rette 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(l) 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 ALLOT-
TED.—

“(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 AWARDED.—

“(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. 1397j(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)”;

(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 non-resident 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)”; and

(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 XXI 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 dis-

tributions 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 policies 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. 1396w-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. JOHANNES, 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 (1) and inserting the following new subsections:

“(1) 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 NON-PREGNANT CHILDLESS ADULTS.—

“(1) NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH 2009.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

“(A) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2009, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

“(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraph (2) shall apply for purposes of any period beginning on 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 NON-PREGNANT 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 Med-

icaid 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.