AMENDMENT TO H.R. _____, AS REPORTED OFFERED BY MR. PRICE OF GEORGIA

[Amendment is to Children's Health Insurance Reauthorization Act of 2009]

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''More Children, More Choices Act of 2009''.

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

TITLE I—SCHIP REAUTHORIZATION

SEC. 101. REQUIRING OUTREACH AND COVERAGE BEFORE EXPANSION OF ELIGIBILITY.

(a) STATE PLAN REQUIRED TO SPECIFY HOW IT WILL ACHIEVE COVERAGE FOR 90 PERCENT OF TARGETED LOW-INCOME CHILDREN.—

(1) IN GENERAL.—Section 2102(a) of the Social Security Act (42 U.S.C. 1397bb(a)) is amended—

(A) in paragraph (6), by striking ''and'' at the end;

(B) in paragraph (7), by striking the period at the end and inserting ''; and''; and

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

''(8) how the eligibility and benefits provided for under the plan for each fiscal year (beginning with fiscal year 2010) will allow for the State's annual funding allotment to cover at least 90 percent of the eligible targeted low-income children in the State.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to State child health plans for fiscal years beginning with fiscal year 2010.

(b) LIMITATION ON PROGRAM EXPANSIONS UNTIL LOWEST INCOME ELIGIBLE INDIVIDUALS ENROLLED.—Section 2105(c) of such Act (42 U.S.C. 1397dd(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATION ON INCREASED COVERAGE OF HIGHER INCOME CHILDREN.—For child health assistance furnished in a fiscal year beginning with fiscal year 2010:

''(A) NO PAYMENT FOR CHILDREN WITH FAMILY INCOME ABOVE 250 PERCENT OF POVERTY LINE.—Payment shall not be made under this section for child health assistance for a targeted low-income child in a family the income of which exceeds 250 percent of the poverty line applicable to a family of the size involved.

''(B) SPECIAL RULES FOR PAYMENT FOR CHILDREN WITH FAMILY INCOME ABOVE 200 PERCENT OF POVERTY LINE.—In the case of child health assistance for a targeted low-income child in a family the income of which ex-

ceeds 200 percent (but does not exceed 250 percent) of the poverty line applicable to a family of the size involved no payment shall be made under this section for such assistance unless the State demonstrates to the satisfaction of the Secretary that—

''(i) the State has met the 90 percent retrospective coverage test specified in subparagraph (C)(i) for the previous fiscal year; and

''(ii) the State will meet the 90 percent prospective coverage test specified in subparagraph (C)(ii) for the fiscal year.

''(C) 90 PERCENT COVERAGE TESTS.—

''(i) RETROSPECTIVE TEST.—The 90 percent retrospective coverage test specified in this clause is, for a State for a fiscal year, that on average during the fiscal year, the State has enrolled under this title or title XIX at least 90 percent of the individuals residing in the State who—

''(I) are children under 19 years of age (or are pregnant women) and are eligible for medical assistance under title XIX; or

''(II) are targeted low-income children whose family income does not exceed 200 percent of the poverty line and who are eligible for child health assistance under this title.

''(ii) PROSPECTIVE TEST.—The 90 percent prospective test specified in this clause is, for a State for a fiscal year, that on average during the fiscal year, the State will enroll under this title or title XIX at least 90 percent of the individuals residing in the State who—

''(I) are children under 19 years of age (or are pregnant women) and are eligible for medical assistance under title XIX; or

''(II) are targeted low-income children whose family income does not exceed such percent of the poverty line (in excess of 200 percent) as the State elects consistent with this paragraph and who are eligible for child health assistance under this title.

''(D) GRANDFATHER.—Subparagraphs (A) and (B) shall not apply to the provision of child health assistance—

''(i) to a targeted low-income child who is enrolled for child health assistance under this title as of September 30, 2007;

''(ii) to a pregnant woman who is enrolled for assistance under this title as of September 30, 2008, through the completion of the post-partum period following completion of her pregnancy; and

''(iii) for items and services furnished before October 1, 2009, to an individual who is not a targeted low-income child and who is enrolled for assistance under this title as of September 30, 2008.

''(E) TREATMENT OF PREGNANT WOMEN.—In this paragraph and sections 2102(a)(8) and 2104(a)(2), the term 'targeted low-income child' includes an individual under age 19, including the period from conception to birth, who is eligible for child health assistance under this title by virtue of the definition of the term 'child' under section 457.10 of title 42, Code of Federal Regulations.''.

(c) STANDARDIZATION OF INCOME DETERMINATIONS.—

(1) IN GENERAL.—Section 2110(d) of such Act (42 U.S.C. 1397jj) is amended by adding at the end the following new subsection:

''(d) STANDARDIZATION OF INCOME DETERMINATIONS.—In determining family income under this title (including in the case of a State child health plan that provides health benefits coverage in the manner described in section 2101(a)(2)), a State shall base such determination on gross income (including amounts that would be included in gross income if they were not exempt from income taxation) and may only take into consideration such income disregards as the Secretary shall develop.''.

(2) EFFECTIVE DATE.—(A) Subject to subparagraph (B), the amendment made by paragraph (1) shall apply to determinations (and redeterminations) of income made on or after April 1, 2009.

(B) In the case of a State child health plan under title XXI of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1), the State child health plan

shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this 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 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.

SEC. 102. APPLICATION OF CITIZENSHIP DOCUMENTATION REQUIREMENTS; INCREASED FEDERAL MATCHING RATE FOR CITIZENSHIP DOCUMENTATION ENFORCEMENT UNDER MEDICAID AND SCHIP.

(a) APPLICATION OF REQUIREMENTS.—

(1) IN GENERAL.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397dd(c)), as amended by section 101(b), is amended by adding at the end the following new paragraph:

''(9) APPLICATION OF CITIZENSHIP DOCUMENTATION REQUIREMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), no payment may be made under this

section to a State with respect to amounts expended for child health assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of section 1903(x) is met.

''(B) TREATMENT OF PREGNANT WOMEN.—For purposes of applying subparagraph (A) in the case of a pregnant woman who qualifies for child health assistance by virtue of the application of section 457.10 of title 42, Code of Federal Regulations, the requirement of such section shall be deemed to be satisfied by the presentation of documentation of personal identity described in section 274A(b)(1)(D) of the Immigration and Nationality Act or any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to eligibility determinations and redeterminations made on or after April 1, 2009.

(b) TEMPORARY INCREASE IN FEDERAL MATCHING RATE FOR ADMINISTRATIVE COSTS UNDER MEDICAID AND SCHIP.——

(1) MEDICAID.—

(A) IN GENERAL.—With respect to administrative costs incurred on or after July 1, 2006, and before October 1, 2009, in implementing the amendments made by section 6036 of the Deficit Reduction Act of 2005 (Public Law 109–171), 75 percent shall be substituted for 50 per centum in section 1903(a)(7) of the Social Security Act (42 U.S.C. 1396b(a)(7)).

(B) RETROACTIVE ADJUSTMENT.—The Secretary of Health and Human Services shall take such steps as may be necessary to provide for the adjustment of payments under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) to take into account the application of subparagraph (A) for periods before the date of the enactment of this Act.

(2) SCHIP.—With respect to administrative costs incurred on or after April 1, 2009, and before October 1, 2009, in implementing the amendment made by subsection (a)(1), the enhanced FMAP applied under section 2105(a)(1)(D)(iv) of the Social

Security Act (42 U.S.C. 1397d(a)(1)(D)(iv)) shall not be less than 75 percent.

SEC. 103. LIMITATIONS ON ELIGIBILITY BASED ON SUBSTANTIAL NET ASSETS.

(a) IN GENERAL.—Section 2110(b) of the Social Security Act (42 U.S.C. 1397jj(b)) is amended—

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

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

''(5) DISQUALIFICATION FOR INDIVIDUALS IN FAMILIES WITH SUBSTANTIAL NET ASSETS.—An individual in a family is not eligible for child health assistance under this title if the individual's family has net assets (including the equity interest in any home) that exceeds $500,000 or unless there is provided a document (in such a form and manner as the Secretary shall specify) signed under penalty of perjury by an applicant for child health assistance on behalf of the individual that the net assets of the individual's family (including the equity interest in the any home) does not exceed $500,000. The Secretary may increase the dollar amount specified in the previous sentence from year to year beginning with 2014 based on the percentage increase in the

consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to eligibility determinations and redeterminations made on or after April 1, 2009.

SEC. 104. CLARIFICATION OF STATE AUTHORITIES.

Section 2102 of the Social Security Act (42 U.S.C. 1397bb) is amended by adding at the end the following new subsection:

''(d) CLARIFICATION OF STATE AUTHORITIES.—Nothing in this title shall be construed as preventing a State, under its child health plan, from doing any of the following:

''(1) USE OF WAITING PERIODS TO PREVENT CROWD OUT.—From using waiting periods and other tools to prevent crowding out private-sector insurance coverage.

''(2) USE OF PRIVATE PROVIDERS AND PLANS.—From cooperating or contracting with private sector providers and plans in order to provide care to targeted low-income children.

''(3) USE OF STATE FUNDS FOR INELIGIBLE INDIVIDUALS.—From providing medical benefits for

individuals who are not targeted low-income children with State funds.''.

SEC. 105. EASING ADMINISTRATIVE BARRIERS TO STATE COOPERATION WITH EMPLOYER-SPONSORED INSURANCE COVERAGE.

(a) REQUIRING SOME COVERAGE FOR EMPLOYER-SPONSORED INSURANCE.—

(1) IN GENERAL.—Section 2102(a) of the Social Security Act (42 U.S.C. 1397b(a)), as amended by section 101(a), is amended—

(A) in paragraph (7), by striking ''and'' at the end;

(B) in paragraph (8), by striking the period at the end and inserting ''; and''; and

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

''(9) effective for plan years beginning on or after October 1, 2009, how the plan will provide for child health assistance with respect to targeted low-income children covered under a group health plan.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply beginning with fiscal year 2010.

(b) FEDERAL FINANCIAL PARTICIPATION FOR EMPLOYER-SPONSORED INSURANCE.—Section 2105 of such Act (42 U.S.C. 1397d) is amended—

(1) in subsection (a)(1)(C), by inserting before the semicolon at the end the following: ''and, subject to paragraph (3)(C), in the form of payment of the premiums for coverage under a group health plan that includes coverage of targeted low-income children and benefits supplemental to such coverage''; and

(2) paragraph (3) of subsection (c) is amended to read as follows:

''(3) PURCHASE OF EMPLOYER-SPONSORED INSURANCE.—

''(A) IN GENERAL.—Payment may be made to a State under subsection (a)(1)(C), subject to the provisions of this paragraph, for the purchase of family coverage under a group health plan that includes coverage of targeted low-income children unless such coverage would otherwise substitute for coverage that would be provided to such children but for the purchase of family coverage.

''(B) WAIVER OF CERTAIN PROVISIONS.—With respect to coverage described in subparagraph (A)—

''(i) notwithstanding section 2102, no minimum benefits requirement (other than those otherwise applicable with respect to services referred to in section 2102(a)(7)) under this title shall apply; and

''(ii) no limitation on beneficiary cost-sharing otherwise applicable under this title or title XIX shall apply.

''(C) REQUIRED PROVISION OF SUPPLEMENTAL BENEFITS.—If the coverage described in subparagraph (A) does not provide coverage for the services referred to in section 2102(a)(7), the State child health plan shall provide coverage of such services as supplemental benefits.

''(D) LIMITATION ON FFP.—The amount of the payment under paragraph (1)(C) for coverage described in subparagraph (A) (and supplemental benefits under subparagraph (C) for individuals so covered) during a fiscal year may not exceed the product of—

''(i) the national per capita expenditure under this title (taking into account both Federal and State expenditures) for the previous fiscal year (as determined by the Secretary using the best available data);

''(ii) the enhanced FMAP for the State and fiscal year involved; and

''(iii) the number of targeted low-income children for whom such coverage is provided.

''(E) VOLUNTARY ENROLLMENT.—A State child health plan—

''(i) may not require a targeted low-income child to enroll in coverage described in subparagraph (A) in order to obtain child health assistance under this title;

''(ii) before providing such child health assistance for such coverage of a child, shall make available (which may be through an Internet website or other means) to the parent or guardian of the child information on the coverage available under this title, including benefits and cost-sharing; and

''(iii) shall provide at least one opportunity per fiscal year for beneficiaries to switch coverage under this title from coverage described in subparagraph (A) to the coverage that is otherwise made available under this title.

''(F) INFORMATION ON COVERAGE OPTIONS.—A State child health plan shall—

''(i) describe how the State will notify potential beneficiaries of coverage described in subparagraph (A);

''(ii) provide such notification in writing at least during the initial application for enrollment under this title and during redeterminations of eligibility if the individual was enrolled before October 1, 2009; and

''(iii) post a description of these coverage options on any official website that may be established by the State in connection with the plan.

''(G) SEMIANNUAL VERIFICATION OF COVERAGE.—If coverage described in subparagraph (A) is provided under a group health plan with respect to a targeted low-income child, the

State child health plan shall provide for the collection, at least once every six months, of proof from the plan that the child is enrolled in such coverage.

''(H) RULE OF CONSTRUCTION.—Nothing in this section is to be construed to prohibit a State from—

''(i) offering wrap around benefits in order for a group health plan to meet any State-established minimum benefit requirements;

''(ii) establishing a cost-effectiveness test to qualify for coverage under such a plan;

''(iii) establishing limits on beneficiary cost-sharing under such a plan;

''(iv) paying all or part of a beneficiary's cost-sharing requirements under such a plan;

''(v) paying less than the full cost of the employee's share of the premium under such a plan, including prorating the cost of the premium to pay for only what the State determines is the portion of the pre-

mium that covers targeted low-income children;

''(vi) using State funds to pay for benefits above the Federal upper limit established under subparagraph (C);

''(vii) allowing beneficiaries enrolled in group health plans from changing plans to another coverage option available under this title at any time; or

''(viii) providing any guidance or information it deems appropriate in order to help beneficiaries make an informed decision regarding the option to enroll in coverage described in subparagraph (A).

''(I) GROUP HEALTH PLAN DEFINED.—In this paragraph, the term 'group health plan' has the meaning given such term in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)).''.

SEC. 106. IMPROVING BENEFICIARY CHOICE IN SCHIP.

(a) REQUIRING OFFERING OF ALTERNATIVE COVERAGE OPTIONS.—Section 2102 of the Social Security Act (42 U.S.C. 1397b), as amended by sections 101(a), 104, and 105(a), is amended—

(1) in subsection (a)—

(A) in paragraph (8), by striking ''and'' at the end;

(B) in paragraph (9), by striking the period at the end and inserting ''; and''; and

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

''(10) effective for plan years beginning on or after October 1, 2009, how the plan will provide for child health assistance with respect to targeted low-income children through alternative coverage options in accordance with subsection (e).''; and

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

''(e) ALTERNATIVE COVERAGE OPTIONS.—

''(1) IN GENERAL.—Effective October 1, 2009, a State child health plan shall provide for the offering of any qualified alternative coverage that a qualified entity seeks to offer to targeted low-income children through the plan in the State.

''(2) APPLICATION OF UNIFORM FINANCIAL LIMITATION FOR ALL ALTERNATIVE COVERAGE OPTIONS.—With respect to all qualified alternative coverage offered in a State, the State child health plan shall establish a uniform dollar limitation on the per capita monthly amount that will be paid by the

State to the qualified entity with respect to such coverage provided to a targeted low-income child. Such limitation may not be less than 90 percent of the per capita monthly payment made for coverage offered under the State child health plan that is not in the form of an alternative coverage option. Nothing in this paragraph shall be construed—

''(A) as requiring a State to provide for the full payment of premiums for qualified alternative coverage;

''(B) as preventing a State from charging additional premiums to cover the difference between the cost of qualified alternative coverage and the amount of such payment limitation;

''(C) as preventing a State from using its own funds to provide a dollar limitation that exceeds the Federal financial participation as limited under section 2105(c)(10).

''(3) QUALIFIED ALTERNATIVE COVERAGE DEFINED.—In this section, the term 'qualified alternative coverage' means health insurance coverage that—

''(A) meets the coverage requirements of section 2103 (other than cost-sharing requirements of such section); and

''(B) is offered by a qualified insurer, and not directly by the State.

''(4) QUALIFIED INSURER DEFINED.—In this section, the term 'qualified insurer' means, with respect to a State, an entity that is licensed to offer health insurance coverage in the State.''.

(b) FEDERAL FINANCIAL PARTICIPATION FOR QUALIFIED ALTERNATIVE COVERAGE.—Section 2105 of such Act (42 U.S.C. 1397d) is amended—

(1) in subsection (a)(1)(C), as amended by section 105(b), by inserting before the semicolon at the end the following: ''and, subject to paragraph (8)(C), in the form of payment of the premiums for coverage for qualified alternative coverage''; and

(2) in subsection (c), as amended by sections 101(b) and 102(a)(1), by adding at the end the following new paragraph:

''(10) PURCHASE OF QUALIFIED ALTERNATIVE COVERAGE.—

''(A) IN GENERAL.—Payment may be made to a State under subsection (a)(1)(C), subject to the provisions of this paragraph, for the purchase of qualified alternative coverage.

''(B) WAIVER OF CERTAIN PROVISIONS.—With respect to coverage described in subpara-

graph (A), no limitation on beneficiary cost-sharing otherwise applicable under this title or title XIX shall apply.

''(C) LIMITATION ON FFP.—The amount of the payment under paragraph (1)(C) for coverage described in subparagraph (A) during a fiscal year in the aggregate for all such coverage in the State may not exceed the product of—

''(i) the national per capita expenditure under this title (taking into account both Federal and State expenditures) for the previous fiscal year (as determined by the Secretary using the best available data);

''(ii) the enhanced FMAP for the State and fiscal year involved; and

''(iii) the number of targeted low-income children for whom such coverage is provided.

''(D) VOLUNTARY ENROLLMENT.—A State child health plan—

''(i) may not require a targeted low-income child to enroll in coverage described

in subparagraph (A) in order to obtain child health assistance under this title;

''(ii) before providing such child health assistance for such coverage of a child, shall make available (which may be through an Internet website or other means) to the parent or guardian of the child information on the coverage available under this title, including benefits and cost-sharing; and

''(iii) shall provide at least one opportunity per fiscal year for beneficiaries to switch coverage under this title from coverage described in subparagraph (A) to the coverage that is otherwise made available under this title.

''(E) INFORMATION ON COVERAGE OPTIONS.—A State child health plan shall—

''(i) describe how the State will notify potential beneficiaries of coverage described in subparagraph (A);

''(ii) provide such notification in writing at least during the initial application for enrollment under this title and during redeterminations of eligibility if the indi-

vidual was enrolled before October 1, 2009; and

''(iii) post a description of these coverage options on any official website that may be established by the State in connection with the plan.

''(F) RULE OF CONSTRUCTION.—Nothing in this section is to be construed to prohibit a State from—

''(i) establishing limits on beneficiary cost-sharing under such alternative coverage;

''(ii) paying all or part of a beneficiary's cost-sharing requirements under such coverage;

''(iii) paying less than the full cost of a child's share of the premium under such coverage, insofar as the premium for such coverage exceeds the limitation established by the State under subparagraph (C);

''(iv) using State funds to pay for benefits above the Federal upper limit established under subparagraph (C); or

''(v) providing any guidance or information it deems appropriate in order to

help beneficiaries make an informed decision regarding the option to enroll in coverage described in subparagraph (A).''.

SEC. 107. ALLOTMENT DISTRIBUTION FORMULA.

(a) ALLOTMENTS TO 50 STATES AND THE DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Section 2104(b) of the Social Security Act (42 U.S.C. 1397dd(b)) is amended—

(A) in paragraph (1), by striking ''the same proportion'' and all that follows and inserting ''the product of the number of SCHIP targeted children, as determined under paragraph (2) for the second preceding fiscal year, the State and Federal per capita SCHIP expenditures for the second preceding fiscal year, as determined under such paragraph, and the enhanced FMAP for the State for the second preceding fiscal year.'';

(B) by amending paragraph (2) to read as follows:

''(2) NUMBER OF SCHIP TARGETED CHILDREN AND PREGNANT WOMEN AND NATIONAL PER CAPITA SCHIP EXPENDITURES.—

''(A) IN GENERAL.—By not later than September 30 of each year (beginning with 2009), the Secretary (in consultation with the Director of the Bureau of the Census and using the best available data for the fiscal year ending in the previous year) shall determine and publish in the Federal Register—

''(i) the average number of low-income targeted children (described in subparagraph (B)) for any month during such preceding fiscal year; and

''(ii) the combined State and Federal per capita SCHIP expenditures (described in subparagraph (C)) for such preceding fiscal year.

''(B) LOW-INCOME SCHIP TARGETED CHILDREN.—Low-income targeted children described in this subparagraph with respect to a subsection (b) State are children (including pregnant women described in section 2105(c)(8)(E)) residing in the State who are not covered under a group health plan or health insurance coverage (as defined for purposes of section 2110(b)(1)(C)) and whose family income—

''(i) exceeds the lesser of—

''(I) the Medicaid applicable income level (as defined in section 2110(b)(4)); or

''(II) 150 percent of the poverty line; but

''(ii) does not 200 percent of the poverty line.

''(C) STATE AND FEDERAL PER CAPITA SCHIP EXPENDITURES.—The State and Federal per capita SCHIP expenditures for a fiscal year is equal to—

''(i) the aggregate Federal and State expenditures made that are attributable to allotments under this title for subsection (b) States for the fiscal year; divided by

''(ii) the average total number of targeted low-income children (including pregnant women described in section 2105(c)(8)(E)) for whom health assistance was made available from such allotments for such fiscal year.''; and

(C) by striking paragraphs (3) and (4) and inserting the following:

''(3) SUBSECTION (B) STATE DEFINED.—In this subsection, the term 'subsection (b) State' means one of the 50 States or the District of Columbia.

''(4) PROPORTIONAL REDUCTION IF TOTAL ALLOTMENTS EXCEED AMOUNT AVAILABLE.—If the Secretary estimates that the total of the allotments under this subsection for a fiscal year (in combination with allotments made under subsection (c)) will exceed the aggregate amount available for allotments for such fiscal year under subsection (a), the Secretary shall reduce the amount of each allotment under this subsection in a pro-rata manner so that such total does not exceed the aggregate amount available for allotments.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to allotments for fiscal years beginning with fiscal year 2010.

(b) NO REDISTRIBUTION OF UNUSED ALLOTMENTS.—

(1) IN GENERAL.—Section 2104(f) of such Act (42 U.S.C. 1397dd) is amended to read as follows:

''(f) NO REDISTRIBUTION OF UNUSED ALLOTMENTS.—There shall be no redistribution of allotments from States that are not expended within the period of availability under subsection (e).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to allotments for fiscal years beginning with fiscal year 2007.

SEC. 108. FIVE-YEAR REAUTHORIZATION.

(a) IN GENERAL.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

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

(2) by striking the period at the end of paragraph (11) and inserting a semicolon; and

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

''(12) for fiscal year 2010, $7,000,000,000;

''(13) for fiscal year 2011, $7,000,000,000;

''(14) for fiscal year 2012, $7,000,000,000;

''(15) for fiscal year 2013, $7,500,000,000; and

''(16) for fiscal year 2014, $8,000,000,000.''.

(b) CONTINUATION OF ADDITIONAL ALLOTMENTS TO TERRITORIES.—Section 2104(c)(4)(B) of the Social Security Act (42 U.S.C. 1397dd(c)(4)(B)) is amended by striking ''2009'' and inserting ''2014''.

(c) APPLICATION TO OTHER SCHIP FUNDING FOR FISCAL YEAR 2010.—Notwithstanding any other provision of law, if funds are appropriated under any law (other than this Act) to provide allotments to States under title

XXI of the Social Security Act for all (or any portion) of fiscal year 2010—

(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 such title XXI 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.

SEC. 109. ENHANCING THE PROGRAMMATIC FOCUS ON CHILDREN AND PREGNANT WOMEN.

(a) IN GENERAL.—Section 2107(f) of the Social Security Act (42 U.S.C. 1397gg(f)) is amended by striking ''childless''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act but shall not apply to projects, including extensions, amendments, or renewals to such projects, that are in effect or have been approved on the date of the enactment of this Act.

SEC. 110. GRANTS FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

"(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

"(1) IN GENERAL.—From the amounts appropriated for a fiscal year under subsection (f), subject to paragraph (2), the Secretary shall award grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

"(2) 10 PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts for the fiscal year shall be used by the Secretary for expenditures during the fiscal year to carry out a national enrollment campaign in accordance with subsection (g).

"(b) AWARD OF GRANTS.—

"(1) PRIORITY FOR AWARDING.—

"(A) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

"(i) propose to target geographic areas with high rates of—

''(I) eligible but unenrolled children, including such children who reside in rural areas; or

''(II) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

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

''(B) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (f) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

''(2) 2-YEAR AVAILABILITY.—A grant awarded under this section for a fiscal year shall remain available for expenditure through the end of the succeeding fiscal year.

''(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

''(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

''(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

''(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

''(4) an assurance that the eligible entity shall—

''(A) conduct an assessment of the effectiveness of such activities against the performance measures;

''(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments; 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) 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 $100,000,000 for each of fiscal years 2010 through 2014.

''(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.''.

TITLE II—CHILD HEALTH INSURANCE COVERAGE THROUGH TAX FAIRNESS

SEC. 201. EXPANSION OF CHILD HEALTH CARE INSURANCE COVERAGE THROUGH TAX FAIRNESS.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 37 as section 38 and by inserting after section 36 the following new section:

"SEC. 37. CHILD HEALTH INSURANCE COSTS.

"(a) IN GENERAL.—In the case of an eligible taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid by the taxpayer during the taxable year for qualified health insurance for any dependent child of such taxpayer.

"(b) LIMITATIONS.—

"(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to an eligible taxpayer for the taxable year shall not exceed the sum of the monthly limitations for coverage months during such taxable year for the individual referred to in subsection (a) for whom such taxpayer paid during the taxable year any amount for coverage under qualified health insurance.

''(2) MONTHLY LIMITATION.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12th of $1,400.

''(3) COVERAGE MONTH.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'coverage month' means, with respect to an individual, any month if—

''(i) as of the first day of such month such individual is covered by qualified health insurance, and

''(ii) the premium for coverage under such insurance for such month is paid by an eligible taxpayer.

''(B) MEDICARE AND MEDICAID.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual—

''(i) is entitled to any benefits under title XVIII of the Social Security Act, or

''(ii) is a participant in the program under title XIX or XXI of such Act.

''(C) CERTAIN OTHER COVERAGE.—Such term shall not include any month during a tax-

able year with respect to an individual if, at any time during such year, any benefit is provided to such individual under chapter 89 of title 5, United States Code.

''(D) INSUFFICIENT PRESENCE IN UNITED STATES.—Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

''(4) INDEXING.—For each taxable year beginning after December 31, 2009, the dollar amount in paragraph (2) (as adjusted for the preceding taxable year by reason of this paragraph) shall be increased or decreased by the percentage change in the average cost of private health insurance for family coverage for such taxable year as compared to such preceding taxable year as computed by the Office of the Actuary of the Centers for Medicare and Medicaid Services, rounded to the nearest whole dollar amount.

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means insurance which constitutes medical care as defined in section 213(d) without regard to—

''(A) paragraph (1)(C) thereof, and

''(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

''(2) EXCLUSION OF CERTAIN OTHER CONTRACTS.—Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).

''(d) ELIGIBLE TAXPAYER; DEPENDENT; CHILD.—For purposes of this section—

''(1) ELIGIBLE TAXPAYER.—The term 'eligible taxpayer' means any taxpayer whose income exceeds 200 percent but not 300 percent of the poverty level applicable to a family of the size involved, as determined in accordance with criteria established by the Director of the Office of Management and Budget.

''(2) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152. An individual to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a

coverage month unless the custodial and noncustodial parent provide otherwise.

''(3) CHILD.—The term 'child' means a qualifying child (as defined in section 152(c).

''(e) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by an eligible taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to such taxpayer as a credit under section 35, as a deduction under section 213(a) or 162(l), or as an exclusion from gross income under section 106 or 125.

''(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(3) MARRIED COUPLES MUST FILE JOINT RETURN.—

''(A) IN GENERAL.—If an eligible taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only

if the taxpayer and his spouse file a joint return for the taxable year.

''(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

''(4) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual's coverage (and such related information as the Secretary may require) is verified in such manner as the Secretary may prescribe.

''(5) INSURANCE WHICH COVERS OTHER INDIVIDUALS; TREATMENT OF PAYMENTS.—Rules similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

''(6) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to an eligible taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.

''(f) COORDINATION WITH ADVANCE PAYMENTS.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to an eligible taxpayer under subsection (a) shall be reduced (but

not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.''.

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to information concerning transactions with other persons) is amended by inserting after section 6050W the following new section:

''SEC. 6050X. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

''(a) IN GENERAL.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under qualified health insurance (as defined in section 37(c)), shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

''(B) the name, address, and TIN of each individual who was provided by such person with coverage under qualified health insurance (as so defined) by reason of such payments and the period of such coverage, and

''(C) such other information as the Secretary may reasonably prescribe.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

''(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(d) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xxi) through (xxii) as clauses (xxii) through (xxv), respectively, and by inserting after clause (xxi) the following new clause:

''(xxii) section 6050X (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by redesignating sub-

paragraphs (EE) and (FF) as subparagraphs (FF) and (GG), respectively, and by inserting after subparagraph (DD) the following new subparagraph:

''(EE) section 6050X(c) (relating to returns relating to payments for qualified health insurance).''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050W the following new item:

''Sec. 6050X. Returns relating to payments for qualified health insurance.''.

(c) ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.—

(1) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

''SEC. 7529. ADVANCE PAYMENT OF HEALTH INSURANCE CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

''(a) GENERAL RULE.—In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to

such individual's qualified health insurance credit advance amount with respect to such provider.

''(b) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual—

''(1) who purchases qualified health insurance (as defined in section 37(c)), and

''(2) for whom a qualified health insurance credit eligibility certificate is in effect.

''(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which—

''(1) certifies that the individual will be eligible to receive the credit provided by section 37 for the taxable year,

''(2) estimates the amount of such credit for such taxable year, and

''(3) provides such other information as the Secretary may require for purposes of this section.

''(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—For purposes of this section, the term 'qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance,

the Secretary's estimate of the amount of credit allowable under section 37 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(2) CLERICAL AMENDMENT.—The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

''Sec. 7529. Advance payment of health insurance credit for purchasers of qualified health insurance.''.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 37 of such Code''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following new items:

''Sec. 37. Health insurance costs.
''Sec. 38. Overpayments of tax.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.

TITLE III—STATE HEALTH REFORM PROJECTS

SEC. 301. STATE HEALTH REFORM PROJECTS.

(a) PURPOSES; ESTABLISHMENT OF STATE HEALTH CARE EXPANSION AND IMPROVEMENT PROGRAM.—

(1) PURPOSES.—The purposes of the programs approved under this section shall include, but not be limited to—

(A) achieving the goals of increased health coverage and access; and

(B) testing alternative reforms, such as building on the public or private health systems, or creating new systems, to achieve the objectives of this Act.

(2) INTENT OF CONGRESS.—It is the intent of Congress that—

(A) the programs approved under this section each comprise significant coverage expansions;

(B) taken as a whole, such programs should be diverse and balanced in their approaches to covering the uninsured; and

(C) each such program should be rigorously and objectively evaluated, so that the State programs developed pursuant to this sec-

tion may guide the development of future State and national policy.

(b) APPLICATIONS BY STATES AND LOCAL GOVERNMENTS.—

(1) ENTITIES THAT MAY APPLY.—

(A) IN GENERAL.—A State may apply for a State health care expansion and improvement program for the entire State (or for regions of the State) under paragraph (2).

(B) REGIONAL AND SUB-STATE GROUPS.—A regional entity consisting of more than one State or one or more local governments within a State may apply for a multi-State or a sub-state health care expansion and improvement program for the region or area involved.

(C) DEFINITION.—In this section, the term ''State'' means the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico. Such term shall include a regional entity described in subparagraph (B).

(2) SUBMISSION OF APPLICATION.—In accordance with this section, each State or regional entity desiring to implement a State health care expansion and improvement program may submit an application to the State Health Coverage Innovation Com-

mission under subsection (c) (referred to in this section as the ''Commission'') for approval.

(3) LOCAL GOVERNMENT APPLICATIONS.—Where a State fails to submit an application under this section, a unit of local government of such State, or a consortium of such units of local governments, may submit an application directly to the Commission for programs or projects under this subsection. Such an application shall be subject to the requirements of this section.

(c) STATE HEALTH COVERAGE INNOVATION COMMISSION.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a State Health Coverage Innovation Commission that—

(A) shall be comprised of—

(i) the Secretary;

(ii) four State governors to be appointed by the National Governors Association on a bipartisan basis;

(iii) two members of a State legislature to be appointed, on a joint and bipartisan basis, by the National Conference of

State Legislators and the American Legislative Exchange Council;

(iv) two county officials to be appointed by the National Association of Counties on a bipartisan basis;

(v) two mayors to be appointed, on a joint and bipartisan basis, by the National League of Cities and by the United States Conference of Mayors;

(vi) two individuals to be appointed by the Speaker of the House of Representatives;

(vii) two individuals to be appointed by the minority leader of the House of Representatives;

(viii) two individuals to be appointed by the majority leader of the Senate; and

(ix) two individuals to be appointed by the minority leader of the Senate;

(B) shall request States to submit proposals, which may include a variety of reform options such as tax credit approaches, expansions of public programs such as Medicaid and the State Children's Health Insurance Program, the creation of purchasing pooling ar-

rangements similar to the Federal Employees Health Benefits Program, individual market purchasing options, single risk pool or single payer systems, health savings accounts, a combination of the options described in this subparagraph, or other alternatives determined appropriate by the Commission, including options suggested by States or the public, and nothing in this subparagraph shall be construed to prevent the Commission from approving a reform proposal not included in this subparagraph;

(C) shall conduct a thorough review of the grant application from a State and carry on a dialogue with all State applicants concerning possible modifications and adjustments;

(D) shall submit the recommendations and legislative proposal described in subsection (d)(4)(C);

(E) shall be responsible for receiving information to determine the status and progress achieved under program or projects granted under this section;

(F) shall report to the public concerning progress made by States with respect to the performance measures and goals established

under this section, the periodic progress of the State relative to its State performance measures and goals, and the State program application procedures, by region and State jurisdiction;

(G) shall promote information exchange between States and the Federal Government;

(H) shall be responsible for making recommendations to the Secretary and the Congress, using equivalency or minimum standards, for minimizing the negative effect of State program on national employer groups, provider organizations, and insurers because of differing State requirements under the programs; and

(I) may require States to submit additional information or reports concerning the status and progress achieved under health care expansion and improvement programs granted under this section, as needed.

(2) PERIOD OF APPOINTMENT; REPRESENTATION REQUIREMENTS; VACANCIES.—Members shall be appointed for a term of 5 years. In appointing such members under paragraph (1)(A), the designated appointing individuals shall ensure the representation of urban and rural areas and an appro-

priate geographic distribution of such members. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(3) CHAIRPERSON, MEETINGS.—

(A) CHAIRPERSON.—The Commission shall select a Chairperson from among its members.

(B) QUORUM.—Two-thirds of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(C) MEETINGS.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting. The Commission shall meet at the call of the Chairperson.

(4) POWERS OF THE COMMISSION.—

(A) NEGOTIATIONS WITH STATES.—The Commission may conduct detailed discussions and negotiations with States submitting applications under this section, either individually or in groups, to facilitate a final set of recommendations for purposes of subsection (d)(4)(C).

(B) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this subsection.

(C) MEETINGS.—In addition to other meetings the Commission may hold, the Commission shall hold an annual meeting with the participating States under this section for the purpose of having States report progress toward the purposes in subsection (a) and for an exchange of information.

(D) INFORMATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this subsection. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission if the head of the department or agency involved determines it appropriate.

(E) POSTAL SERVICES.—The Commission may use the United States mails in the same

manner and under the same conditions as other departments and agencies of the Federal Government.

(5) PERSONNEL MATTERS.—

(A) COMPENSATION.—Each member of the Commission who is not an officer or employee of the Federal Government or of a State or local government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their

homes or regular places of business in the performance of services for the Commission.

(C) STAFF.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(D) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(E) TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(6) FUNDING.—For the purpose of carrying out this subsection, there are authorized to be appropriated $3,000,000 for fiscal year 2008 and each fiscal year thereafter.

(d) REQUIREMENTS FOR PROGRAMS.—

(1) STATE PLAN.—A State that seeks to operate a program under this section shall prepare and submit to the Commission, as part of the application under subsection (b), a State health care plan that shall have as its goal increased coverage, and in service of that goal such additional goals as improvements in quality, efficiency, cost-effectiveness, and the appropriate use of information technology. To achieve such goal, the State plan shall comply with the following:

(A) COVERAGE.—

(i) IN GENERAL.—With respect to coverage, the State plan shall—

(I) provide and describe the manner in which the State will ensure that an increased number of individuals residing within the State will have expanded access to health care coverage with a specific 5-year target for reduction in the number or proportion of

uninsured individuals through either private or public program expansion, or both, in accordance with or in addition to the options established by the Commission;

(II) describe the number and percentage of current uninsured individuals who will achieve coverage under a State health program;

(III) describe the coverage that will be provided to beneficiaries under a State health program;

(IV) identify Federal, State, or local and private programs that currently provide health care services in the State and describe how such programs could be coordinated with a State health program, to the extent practicable; and

(V) provide for improvements in the availability of appropriate health care coverage that will increase access to care in urban, suburban, rural, and frontier areas of the State with medically underserved populations or

where there may be an inadequate supply of health care providers.

(ii) COVERAGE OPTIONS.—The coverage under the State plan may be—

(I) health insurance coverage that meets the aggregate actuarial value requirement of section 2103(a)(2)(B) of the Social Security Act (42 U.S.C. 1397cc(a)(2)(B));

(II) a combination of health insurance coverage and a consumer-directed health care spending account, if the actuarial value of such coverage plus the amount of annual deposits into such account from sources other than the beneficiary is not less than the actuarial value amount described in subclause (I); or

(III) health care access not less on average than that provided through coverage described in subclause (I).

(iii) CONSTRUCTION.—Nothing in this clause shall be construed to limit in any way the authority of the Secretary of

Health and Human Services to issue waivers under section 1115 of the Social Security Act.

(B) QUALITY.—With respect to quality, the State plan may describe efforts to improve health care quality in the State, including an explanation of how such efforts would change (if at all) under the State plan.

(C) COSTS.—With respect to costs, the State plan shall—

(i) describe such steps as the State may undertake to improve the efficiency of health care;

(ii) describe the public and private sector financing to be provided for the State health program;

(iii) estimate the amount of Federal, State, and local expenditures, as well as, the costs to business and individuals under the State health program; and

(iv) describe how the State plan will ensure the financial solvency of the State health program.

(D) HEALTH INFORMATION TECHNOLOGY.—With respect to health information

technology, the State plan may describe efforts to improve the appropriate use of health information technology, including an explanation of how such efforts would change (if at all) under the State plan.

(E) EXCEPTIONS TO FEDERAL POLICIES.—The State plan shall describe the exceptions to otherwise applicable Federal statutes, regulations, and policies that would apply within the geographic area and time period governed by the plan.

(2) TECHNICAL ASSISTANCE.—The Secretary shall, if requested, provide technical assistance to States to assist such States in developing applications and plans under this section, including technical assistance by private sector entities if determined appropriate by the Commission.

(3) INITIAL REVIEW.—With respect to a State application under subsection (b), the Secretary and the Commission shall complete an initial review of such State application within 60 days of the receipt of such application, analyze the scope of the proposal, and determine whether additional information is needed from the State. The Commission shall ad-

vise the State within such period of the need to submit additional information.

(4) FINAL DETERMINATION.—

(A) IN GENERAL.—In a timely manner consistent with subparagraph (C), the Commission shall determine whether to submit a State proposal to Congress for approval.

(B) VOTING.—

(i) IN GENERAL.—The determination to submit a State proposal to Congress under subparagraph (A) shall be approved by ⅔ of the members of the Commission who are present and eligible to vote and a majority of the entire Commission.

(ii) ELIGIBILITY.—A member of the Commission shall not participate in a determination under subparagraph (A) if—

(I) in the case of a member who is a Governor, such determination relates to the State of which the member is the Governor; or

(II) in the case of member not described in subclause (I), such determination relates to the geographic area of a State of which such member

serves as a State or local official or as a Member of Congress.

(C) SUBMISSION.—Not later than 90 days prior to October 1 of each fiscal year, the Commission may submit to Congress a list, in the form of a legislative proposal, of the State applications that the Commission recommends for approval under this section.

(5) PROGRAM OR PROJECT PERIOD.—A State program or project may be approved for a period of 5 years and may be extended for a subsequent period of time upon approval by the Commission, based upon achievement of targets.

(e) EXPEDITED CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION AND EXPEDITED CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(A) INTRODUCTION IN HOUSE OF REPRESENTATIVES.—The legislative proposal submitted pursuant to subsection (d)(4)(C) shall be in the form of a joint resolution (in this subsection referred to as the ''resolution''). Such resolution shall be introduced in the House of Representatives by the Speaker immediately upon receipt of the language and shall be referred non-sequentially to the appropriate com-

mittee (or committees) of House of Representatives. If the resolution is not introduced in accordance with the preceding sentence, the resolution may be introduced by any member of the House of Representatives.

(B) COMMITTEE CONSIDERATION.—Not later than 15 calendar days after the introduction of the resolution described in subparagraph (A), each committee of House of Representatives to which the resolution was referred shall report the resolution. The report may include, at the committee's discretion, a recommendation for action by the House. If a committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its introduction or at the end of the first day after there has been reported to the House a resolution, whichever is earlier, such committee shall be deemed to be discharged from further consideration of such resolution and such resolution shall be placed on the appropriate calendar of the House of Representatives.

(C) EXPEDITED PROCEDURE IN HOUSE.—Not later than 5 legislative days after the date on which all committees have been discharged

from consideration of a resolution, the Speaker of the House of Representatives, or the Speaker's designee, shall move to proceed to the consideration of the resolution. It shall also be in order for any member of the House of Representatives to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution is highly privileged in the House of Representatives and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives shall immediately proceed to consideration of the resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the House of Representatives until disposed of.

A motion to recommit the resolution shall not be in order. Upon its passage in the House, the clerk of the House shall provide for its immediate transmittal to the Senate.

(2) EXPEDITED CONSIDERATION IN THE SENATE.—

(A) REFERRAL TO COMMITTEE.—If the resolution is agreed to by the House of Representatives, upon its receipt in the Senate the majority leader of the Senate, or the leader's designee, the resolution shall be referred to the appropriate committee of Senate.

(B) COMMITTEE CONSIDERATION.—Not later than 15 calendar days after the referral of the resolution under subparagraph (A), the committee of the Senate to which the resolution was referred shall report the resolution. The report may include, at the committee's discretion, a recommendation for action by the Senate. If a committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its referral or at the end of the first day after there has been reported to the Senate a resolution, whichever is earlier, such committee shall be deemed to be discharged

from further consideration of such resolution and such resolution shall be placed on the appropriate calendar of the Senate.

(C) EXPEDITED FLOOR CONSIDERATION.—Not later than 5 legislative days after the date on which all committees have been discharged from consideration of a resolution, the majority leader of the Senate, or the majority leader's designee, shall move to proceed to the consideration of the resolution. It shall also be in order for any member of the Senate to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution in the Senate is privileged and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the Senate shall imme-

diately proceed to consideration of the resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the Senate until disposed of.

(3) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution under this subsection, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(4) FEDERAL BUDGET NEUTRALITY.—Except insofar as it allots appropriations made pursuant to

subsection (k), the legislative proposal submitted pursuant to subsection (d)(4)(C) may not increase the cumulative, net Federal budget deficit during the multi-year operation of all the State applications contained therein, taking into account such applications' impact on Federal mandatory and discretionary spending, Federal revenue, and Federal tax expenditures.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide a grant to a State that has an application approved under subsection (e) to enable such State to carry out an innovative State health program in the State, to the extent that such a grant is included in the recommendation of the Commission.

(2) AMOUNT OF GRANT.—The amount of a grant provided to a State under paragraph (1) shall be determined based upon the recommendations of the Commission, subject to the amount appropriated under subsection (k).

(3) PERFORMANCE-BASED FUNDING ALLOCATION.—In awarding grants under paragraph (1), the Commission shall direct the Secretary to—

(A) fund a balanced diversity of approaches as provided for by the Commission in subsection (c)(1)(B); and

(B) link allocations to the State to the meeting of the goals and performance measures relating to health care coverage and health care costs established under this section through the State project application process.

(4) REPORT.—One year prior to the end of the 5-year period beginning on the date on which the first State begins to implement a plan approved under subsection (e), the Commission shall prepare and submit to the appropriate committees of Congress, a report on the progress made by States in meeting the goals of expanded coverage and cost containment through performance measures established during the 5-year period of the State plan. Such report may contain the recommendation of the Commission concerning any future action that Congress should take concerning health care reform, including whether or not to extend the program established under this subsection.

(g) MONITORING AND EVALUATION.—

(1) ANNUAL REPORTS AND PARTICIPATION BY STATES.—Each State that has received a program approval shall—

(A) submit to the Commission an annual report based on the period representing the respective State's fiscal year, detailing compliance with the requirements established by the Commission and the Secretary in the approval and in this section; and

(B) participate in the annual meeting under subsection (c)(4)(C).

(2) EVALUATIONS BY COMMISSION.—The Commission shall prepare and submit to the Congress annual reports that shall contain—

(A) a description of the effects of the reforms undertaken in States receiving approvals under this section;

(B) a description of the recommendations of the Commission and actions taken based on these recommendations;

(C) an independent evaluation of the effectiveness of such reforms in—

(i) expanding health care coverage for State residents; and

(ii) reducing or containing health care costs in the States,

as well as other relevant or significant findings;

(D) recommendations regarding the advisability of increasing Federal financial assistance for State ongoing or future health program initiatives, including the amount and source of such assistance; and

(E) as required by the Commission or the Secretary under this section, a periodic, independent evaluation of the program.

(h) NONCOMPLIANCE.—

(1) CORRECTIVE ACTION PLANS.—If a State is not in compliance with a requirement of this section, the Commission, on recommendation of the Secretary, shall develop a corrective action plan for such State.

(2) TERMINATION.—The Commission, on recommendation of the Secretary, may revoke any program granted under this section. Such decisions shall be subject to a petition for reconsideration and appeal pursuant to regulations established by the Secretary.

(i) RELATIONSHIP TO FEDERAL PROGRAMS.—

(1) IN GENERAL.—Nothing in this section, or in section 1115 of the Social Security Act (42 U.S.C. 1315) shall be construed as authorizing the Secretary, the Commission, a State, or any other person or entity to alter or affect in any way the provisions of title XIX of such Act (42 U.S.C. 1396 et seq.) or the regulations implementing such title.

(2) MAINTENANCE OF EFFORT.—No payment may be made under subsection (f)(1) if the State adopts criteria for benefits or criteria for standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those required under Federal law and applied as of the date of enactment of this Act.

(j) MISCELLANEOUS PROVISIONS.—

(1) APPLICATION OF CERTAIN REQUIREMENTS.—

(A) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

(i) IN GENERAL.—Subject to subparagraph (B), a State shall not permit the imposition of any preexisting condition exclusion for covered benefits under a program or project under this section.

(ii) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State program or project provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the program or project may permit the imposition of a preexisting condition exclusion but only insofar and to the extent that such exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(B) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under the program or project shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(2) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under subsection (f)(1) for expenditures for health assistance provided for an individual to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided health assistance under the plan.

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in any other provision of law, no payment shall be made to a State under subsection (f)(1) for expenditures for health assistance provided for an individual to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program. For

purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) of the Social Security Act shall apply.

(3) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following provisions of the Social Security Act shall apply to States under subsection (f)(1) in the same manner as they apply to a State under such title XIX:

(A) TITLE XIX PROVISIONS.—

(i) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(ii) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(iii) Section 1903(w) (relating to limitations on provider taxes and donations).

(iv) Section 1920A (relating to presumptive eligibility for children).

(B) TITLE XI PROVISIONS.—

(i) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(ii) Section 1124 (relating to disclosure of ownership and related information).

(iii) Section 1126 (relating to disclosure of information about certain convicted individuals).

(iv) Section 1128A (relating to civil monetary penalties).

(v) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(vi) Section 1132 (relating to periods within which claims must be filed).

(4) RELATION TO HIPAA.—Health benefits coverage provided under a State program or project under this section shall be treated as creditable coverage for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary in each fiscal year. Amounts appropriated for a fiscal year under this sub-

section and not expended may be used in subsequent fiscal years to carry out this section.

TITLE IV—SENSE OF THE HOUSE OF REPRESENTATIVES

SEC. 401. MEDICARE AND MEDICAID REFORM AND SAVINGS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall implement administrative reforms with respect to—

(1) the Medicare program under title XVIII of the Social Security Act in—

(A) the reduction of fraud and abuse in the program,

(B) health information technology,

(C) comparative effectiveness, and

(D) chronic disease management; and

(2) the Medicaid program under title XIX of the Social Security Act, including changes in the Medicaid matching rate and changes in the payments for Medicaid administrative costs to prevent duplication of such payments under the temporary assistance for needy families program under title IV of the Social Security Act;

that are sufficient to result in projected reductions in the Medicare and Medicaid Federal budget baselines for fiscal

years 2010 through 2015 that exceed the projected revenue loss for the same period attributable to the refundable portion of the tax credit under section 37 of the Internal Revenue Code of 1986 (as added by title II of this Act) and the increase in the Federal budget baseline for the State children's health insurance program under title XXI of the Social Security Act from the provisions of and amendments made by title I of this Act.

(b) CONSULTATION AND CONSIDERATION.—In developing the necessary program changes under subsection (a), the Secretary of Health and Human Services shall consult with the Government Accountability Office and the Medicare Payment Advisory Commission and shall also consider any significant proposals for program changes in the specified areas that have been issued by private organizations within the last 3 years.