

REPORT OF CONFERENCE COMMITTEE

MR. SPEAKER AND MR. PRESIDENT:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

H. B. No. 1725: Medicaid; seek federal waiver for plan to allow Medicaid coverage for persons described in the federal Affordable Care Act.

We, therefore, respectfully submit the following report and recommendation:

1. That the Senate recede from its Amendment No. 1.
2. That the House and Senate adopt the following amendment:

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

63 SECTION 1. (1) The Office of the Governor, Division of
64 Medicaid, shall enter into negotiations with the Centers for
65 Medicare and Medicaid Services (CMS) to obtain a waiver for
66 applicable provisions of the Medicaid laws and regulations under
67 Section 1115 of the federal Social Security Act to create a plan
68 to allow Medicaid coverage in Mississippi for individuals
69 described in this act, which contains the following provisions:

70 (a) Coverage group. Individuals eligible for coverage
71 under this section shall be persons who are not less than nineteen
72 (19) years of age but less than sixty-five (65) years of age, who
73 currently reside in households that have an income of not more
74 than one hundred thirty-eight percent (138%) of the federal

75 poverty level, and to the extent approved by CMS in the Section
76 1115 waiver, who are:

77 (i) Employed for at least one hundred twenty (120)
78 hours per month in a position for which health insurance is not
79 paid for by the employer;

80 (ii) Enrolled as a full-time student in secondary
81 or post-secondary education;

82 (iii) Enrolled full-time in a workforce training
83 program;

84 (iv) Enrolled for at least six (6) credit hours,
85 or its equivalent, as a student in secondary education,
86 post-secondary education, or a workforce training program and is
87 employed for at least sixty (60) hours per month in a position for
88 which health insurance is not paid for by the employer;

89 (v) The parent or guardian and the primary
90 caregiver of a child under six (6) years of age;

91 (vi) A person who is physically, mentally or
92 intellectually unable to meet the requirements of subparagraphs
93 (i) through (iv) of this paragraph (a) as documented by a medical
94 professional; or

95 (vii) The primary caregiver for a disabled child,
96 spouse or parent, provided that such disabled person qualifies for
97 Medicaid coverage in accordance with the federal Social Security
98 Act.

99 (b) Beneficiary enrollment. Any individual otherwise
100 eligible for coverage under this section who has health insurance
101 coverage through his or her employer or through private health
102 insurance and who voluntarily disenrolls from that health
103 insurance coverage shall not be in the coverage group until twelve
104 (12) months after the ending date of that coverage. The coverage
105 group shall not include non-United States citizens who are
106 ineligible for Medicaid benefits. The division shall verify
107 eligibility of each beneficiary in this coverage group no less
108 than on an annual basis. The division may consider seasonal or
109 part-time employees who are cumulatively employed for an average
110 of one hundred twenty (120) hours per month over a twelve-month
111 period as satisfying the work requirements of paragraph (a)(i) of
112 this subsection.

113 The division shall provide qualified providers with such
114 forms as are necessary for an individual in the coverage group to
115 make application for Medicaid and information on how to assist
116 such individuals in completing and filing such forms. The
117 division shall make those application forms and the application
118 process itself as simple as possible. In addition to the efforts
119 of the division, the Department of Health shall administer a
120 public awareness program regarding the coverage and eligibility
121 offered in accordance with this act. Such program shall promote
122 public awareness of the coverage offered in accordance with this
123 act to ensure that all eligible citizens of the State of

124 Mississippi are aware of and have the opportunity to apply for
125 eligibility.

126 (c) Delivery systems.

127 (i) All individuals in the coverage group who
128 currently reside in households that have an income of less than
129 one hundred percent (100%) of the federal poverty level shall be
130 enrolled in and their services shall be provided by the managed
131 care organizations (MCOs), coordinated care organizations (CCOs),
132 provider-sponsored health plans (PSHPs) and other such
133 organizations paid for services to the Medicaid population on a
134 capitated basis by the division as described in Section
135 43-13-117(H).

136 (ii) All individuals in the coverage group who
137 currently reside in households that have an income of at least one
138 hundred percent (100%) of the federal poverty level but not more
139 than one hundred thirty-eight percent (138%) of the federal
140 poverty level shall be enrolled in and their services shall be
141 provided by a qualified health plan in accordance with Section 3
142 of this act. Any individual who meets the income thresholds of
143 this subparagraph (ii), but is deemed medically frail by the
144 Division, may be enrolled in and their services shall be provided
145 by a managed care organizations (MCOs), coordinated care
146 organizations (CCOs), provider sponsored health plans (PSHPs) and
147 other such organizations paid for services to the Medicaid
148 population on a capitated basis by the division as described in

149 Section 43-13-117(H), or through the division's fee-for-service
150 program.

151 (d) Benefit packages. Individuals enrolled under this
152 act who are not less than nineteen (19) years of age but less than
153 sixty five (65) years of age shall be provided essential health
154 services as determined by the division, which shall, at a minimum,
155 include ambulatory patient services, emergency services,
156 hospitalization, prescription drugs, rehabilitative services,
157 laboratory services, primary care services, preventive and
158 wellness services and chronic disease management.

159 (e) Funding of the plan.

160 (i) The Section 1115 waiver described in this
161 section shall describe the funding for this act, which shall be a
162 combination of state matching funds and federal matching funds in
163 the proportions specified under the federal Affordable Care Act at
164 the time of the effective date of this act.

165 (ii) The state matching funds shall include
166 contributions from MCOs, CCOs, PSHPs and other such organizations
167 paid for services to the Medicaid population on a capitated basis
168 by the division as described in Section 43-13-117(H) in the form
169 of an assessment as provided in Section 2 of this act and all
170 other revenue sources as provided in this act. The state matching
171 funds shall also include contributions from hospitals that are
172 generated through an assessment on hospitals as described in

173 Section 43-13-145 and deposited into the Medical Care Fund created
174 in Section 43-13-143.

175 (iii) The division is also authorized to accept
176 any voluntary contributions donated to the division to be used as
177 state matching funds for the purpose of this act, including, but
178 not limited to, contributions from businesses and other entities.

179 (iv) If the funds derived from subparagraphs (ii)
180 through (iii) of this paragraph and Sections 27-15-103 (4) and
181 27-15-109 (4) are lower than the amount needed to account for the
182 state's matching funds, funds derived from the three percent (3%)
183 taxes levied in Sections 27-15-103 and 27-15-109 shall be diverted
184 to account for the state's matching funds. Notwithstanding any
185 provision of this paragraph (e), state matching funds for the
186 purposes of this act may also be appropriated by the Legislature
187 from any other sources.

188 (f) Timing. Within one hundred twenty (120) days of
189 the effective date of this act, the division shall apply for a
190 waiver of the applicable provisions of the Medicaid laws and
191 regulations under Section 1115 of the federal Social Security Act
192 to create a plan to allow Medicaid coverage in Mississippi in
193 accordance with this act, which shall include a work requirement
194 that requires beneficiaries to be employed for at least one
195 hundred twenty (120) hours per month or for such beneficiary to be
196 otherwise eligible within paragraph (a) of this subsection. The
197 division shall provide a copy of such application to the Governor,

198 Lieutenant Governor, Speaker of the House of Representatives, and
199 the Chairmen of the Senate and House Medicaid Committees on the
200 same day that the division officially applies to CMS for such
201 waiver.

202 (2) The division shall begin enrolling eligible individuals
203 into the coverage group established in this section within thirty
204 (30) days of the effective date of CMS approving the division's
205 waiver under this section.

206 (3) By December 1 of each year, the division shall provide
207 the Legislature with a report that contains a recommendation on
208 methods to provide better health outcomes, cost-containment
209 measures and utilization management.

210 (4) If CMS rejects the division's work requirement waiver
211 request as provided in this act, the division, by and through the
212 attorney general, shall appeal the decision to a court of
213 competent jurisdiction within thirty (30) days. During any such
214 appeal provided in this subsection, the division may reapply for a
215 work requirement waiver request if CMS approves a work requirement
216 waiver in another state.

217 (5) This section shall stand repealed on January 31, 2029.

218 (6) This section shall be subject to Section 4 of this act.

219 **SECTION 2.** (1) Notwithstanding any other provision of law,
220 upon each managed care organization, coordinated care
221 organization, provider sponsored health plan or other organization
222 paid for services to the Medicaid population on a capitated basis

223 by the Division of Medicaid as described in Section 43-13-117(H),
224 there is levied an assessment of three percent (3%) on the total
225 paid capitation. All assessments under this section shall be
226 assessed and collected by the division on the 15th of each month
227 and shall be deposited into the Medicaid Beneficiaries Coverage
228 Special Fund created by subsection (2) of this section. Any
229 amount generated by the assessment that is in excess of the amount
230 needed to cover the state matching funds may be used to enhance
231 provider reimbursement for those services that are most utilized
232 by the coverage group as determined by the division. This section
233 shall be effective in the first month that a capitated payment is
234 provided to a managed care organization, coordinated care
235 organization, provider sponsored health plan or other organization
236 paid for services to the Medicaid population on a capitated basis
237 by the division as described in Section 43-13-117(H) for coverage
238 of individuals eligible under Section 1 of this act and Section
239 43-13-115. The Division of Medicaid is directed to apply for any
240 applicable federal waiver to accomplish the purposes of this
241 section.

242 (2) There is created in the State Treasury a special fund to
243 be known as the "Medicaid Beneficiaries Coverage Special Fund,"
244 for the purpose of providing the state's share of funding the plan
245 provided in this act. The fund shall be comprised of monies
246 collected from the following sources:

247 (a) The assessment provided in subsection (1) of this
248 section;

249 (b) The assessment provided in Section 27-15-103(4);

250 (c) The assessment provided in Section 27-15-109(4);

251 and

252 (d) Any amounts provided from CMS as the federal
253 matching fund proportion for medical services provided to the
254 coverage group.

255 (3) Unexpended monies remaining in the Medicaid
256 Beneficiaries Coverage Special Fund at the end of a fiscal year
257 shall not lapse into the State General Fund, and any interest
258 earned on monies in the fund shall be deposited to the credit of
259 the fund.

260 (4) This section shall stand repealed on January 31, 2029.

261 (5) This section shall be subject to Section 4 of this act.

262 **SECTION 3.** (1) For purposes of this section, the following
263 terms shall have the meanings ascribed herein:

264 (a) "Cost-sharing" means the portion of the cost of a
265 covered medical service that must be paid by or on behalf of
266 eligible individuals, consisting of copayments, coinsurance and
267 deductibles.

268 (b) "Eligible individuals" means individuals who:

269 (i) Are in the coverage group provided in Section
270 1(a) of this act and who currently reside in households that have
271 an income of at least one hundred percent (100%) of the federal

272 poverty level but not more than one hundred thirty-eight percent
273 (138%) of the federal poverty level; and

274 (ii) Are not determined to be medically frail by
275 the division such that coverage through a qualified health plan is
276 determined to be impractical, overly complex, or would undermine
277 continuity or effectiveness of care.

278 (c) "Exchange" means a state, federal, or partnership
279 exchange or marketplace operating in Mississippi.

280 (d) "Insurer" means any entity that provides or offers
281 a qualified health plan.

282 (c) "Premium" means a charge that must be paid as a
283 condition of enrolling in health care coverage.

284 (c) "Qualified health plan" means a State Insurance
285 Department certified individual health insurance plan offered by
286 an insurer through the exchange.

287 (2) All eligible beneficiaries under this section shall be
288 offered health coverage through a qualified health plan offered by
289 an insurer through the exchange. The division shall ensure only
290 the most cost-effective plans are offered to eligible
291 beneficiaries.

292 (3) The division shall pay up to ten percent (10%) of the
293 premiums and cost-sharing of any qualified health plan provided to
294 an eligible beneficiary.

295 (4) If a state-based exchange is implemented after the
296 effective date of this act, then all eligible beneficiaries shall

297 be transitioned to qualified health plans offered on the
298 state-based exchange.

299 (5) This section shall stand repealed on January 31, 2029.

300 (6) This section shall be subject to Section 4 of this act.

301 **SECTION 4.** (1) Sections 1 through 4 of this act and
302 Sections 43-13-115(29), 27-15-103(4) and 27-15-109(4) shall stand
303 repealed on the date of any of the following:

304 (a) On such date that a court of competent jurisdiction
305 upholds the Centers for Medicare and Medicaid Services (CMS)
306 rejection of the division's work requirement waiver request
307 provided for in Section 1 of this act;

308 (b) On such date that the Centers for Medicare and
309 Medicaid Services (CMS) reject the assessment provided for in
310 Section 2 of this act;

311 (c) On such date that the Centers for Medicare and
312 Medicaid Services (CMS) withdraws approval of, cancels or
313 constructively terminates any waiver that was previously issued to
314 the division as a condition of the requirements of this act;

315 (d) On such date that a court of competent jurisdiction
316 nullifies the work requirement provided for in Section 1 of this
317 act;

318 (e) On such date that a court of competent jurisdiction
319 nullifies the assessment provided for in Section 2 of this act; or

320 (f) On such date that the federal matching fund
321 proportion for medical services provided to the coverage group

322 ever falls below ninety percent (90%), or as close to that date as
323 required in order for the division to comply with any federal
324 notice and due process requirements.

325 (2) If the division receives a waiver in accordance with
326 Sections 1 and 2 of this act, but the act is later repealed
327 through any of the events or actions listed in subsection (1) of
328 this section, then the division shall have ninety (90) days to
329 cease coverage of eligible individuals under this act and to
330 provide notice to such individuals of the termination of coverage.

331 **SECTION 5.** Section 43-13-115, Mississippi Code of 1972, is
332 amended as follows:

333 43-13-115. Recipients of Medicaid shall be the following
334 persons only:

335 (1) Those who are qualified for public assistance
336 grants under provisions of Title IV-A and E of the federal Social
337 Security Act, as amended, including those statutorily deemed to be
338 IV-A and low income families and children under Section 1931 of
339 the federal Social Security Act. For the purposes of this
340 paragraph (1) and paragraphs (8), (17) and (18) of this section,
341 any reference to Title IV-A or to Part A of Title IV of the
342 federal Social Security Act, as amended, or the state plan under
343 Title IV-A or Part A of Title IV, shall be considered as a
344 reference to Title IV-A of the federal Social Security Act, as
345 amended, and the state plan under Title IV-A, including the income
346 and resource standards and methodologies under Title IV-A and the

347 state plan, as they existed on July 16, 1996. The Department of
348 Human Services shall determine Medicaid eligibility for children
349 receiving public assistance grants under Title IV-E. The division
350 shall determine eligibility for low income families under Section
351 1931 of the federal Social Security Act and shall redetermine
352 eligibility for those continuing under Title IV-A grants.

353 (2) Those qualified for Supplemental Security Income
354 (SSI) benefits under Title XVI of the federal Social Security Act,
355 as amended, and those who are deemed SSI eligible as contained in
356 federal statute. The eligibility of individuals covered in this
357 paragraph shall be determined by the Social Security
358 Administration and certified to the Division of Medicaid.

359 (3) Qualified pregnant women who would be eligible for
360 Medicaid as a low income family member under Section 1931 of the
361 federal Social Security Act if her child were born. The
362 eligibility of the individuals covered under this paragraph shall
363 be determined by the division.

364 (4) [Deleted]

365 (5) A child born on or after October 1, 1984, to a
366 woman eligible for and receiving Medicaid under the state plan on
367 the date of the child's birth shall be deemed to have applied for
368 Medicaid and to have been found eligible for Medicaid under the
369 plan on the date of that birth, and will remain eligible for
370 Medicaid for a period of one (1) year so long as the child is a
371 member of the woman's household and the woman remains eligible for

372 Medicaid or would be eligible for Medicaid if pregnant. The
373 eligibility of individuals covered in this paragraph shall be
374 determined by the Division of Medicaid.

375 (6) Children certified by the State Department of Human
376 Services to the Division of Medicaid of whom the state and county
377 departments of human services have custody and financial
378 responsibility, and children who are in adoptions subsidized in
379 full or part by the Department of Human Services, including
380 special needs children in non-Title IV-E adoption assistance, who
381 are approvable under Title XIX of the Medicaid program. The
382 eligibility of the children covered under this paragraph shall be
383 determined by the State Department of Human Services.

384 (7) Persons certified by the Division of Medicaid who
385 are patients in a medical facility (nursing home, hospital,
386 tuberculosis sanatorium or institution for treatment of mental
387 diseases), and who, except for the fact that they are patients in
388 that medical facility, would qualify for grants under Title IV,
389 Supplementary Security Income (SSI) benefits under Title XVI or
390 state supplements, and those aged, blind and disabled persons who
391 would not be eligible for Supplemental Security Income (SSI)
392 benefits under Title XVI or state supplements if they were not
393 institutionalized in a medical facility but whose income is below
394 the maximum standard set by the Division of Medicaid, which
395 standard shall not exceed that prescribed by federal regulation.

396 (8) Children under eighteen (18) years of age and
397 pregnant women (including those in intact families) who meet the
398 financial standards of the state plan approved under Title IV-A of
399 the federal Social Security Act, as amended. The eligibility of
400 children covered under this paragraph shall be determined by the
401 Division of Medicaid.

402 (9) Individuals who are:

403 (a) Children born after September 30, 1983, who
404 have not attained the age of nineteen (19), with family income
405 that does not exceed one hundred percent (100%) of the nonfarm
406 official poverty level;

407 (b) Pregnant women, infants and children who have
408 not attained the age of six (6), with family income that does not
409 exceed one hundred thirty-three percent (133%) of the federal
410 poverty level; and

411 (c) Pregnant women and infants who have not
412 attained the age of one (1), with family income that does not
413 exceed one hundred eighty-five percent (185%) of the federal
414 poverty level.

415 The eligibility of individuals covered in (a), (b) and (c) of
416 this paragraph shall be determined by the division.

417 (10) Certain disabled children age eighteen (18) or
418 under who are living at home, who would be eligible, if in a
419 medical institution, for SSI or a state supplemental payment under
420 Title XVI of the federal Social Security Act, as amended, and

421 therefore for Medicaid under the plan, and for whom the state has
422 made a determination as required under Section 1902(e)(3)(b) of
423 the federal Social Security Act, as amended. The eligibility of
424 individuals under this paragraph shall be determined by the
425 Division of Medicaid.

426 (11) Until the end of the day on December 31, 2005,
427 individuals who are sixty-five (65) years of age or older or are
428 disabled as determined under Section 1614(a)(3) of the federal
429 Social Security Act, as amended, and whose income does not exceed
430 one hundred thirty-five percent (135%) of the nonfarm official
431 poverty level as defined by the Office of Management and Budget
432 and revised annually, and whose resources do not exceed those
433 established by the Division of Medicaid. The eligibility of
434 individuals covered under this paragraph shall be determined by
435 the Division of Medicaid. After December 31, 2005, only those
436 individuals covered under the 1115(c) Healthier Mississippi waiver
437 will be covered under this category.

438 Any individual who applied for Medicaid during the period
439 from July 1, 2004, through March 31, 2005, who otherwise would
440 have been eligible for coverage under this paragraph (11) if it
441 had been in effect at the time the individual submitted his or her
442 application and is still eligible for coverage under this
443 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
444 coverage under this paragraph (11) from March 31, 2005, through
445 December 31, 2005. The division shall give priority in processing

446 the applications for those individuals to determine their
447 eligibility under this paragraph (11).

448 (12) Individuals who are qualified Medicare
449 beneficiaries (QMB) entitled to Part A Medicare as defined under
450 Section 301, Public Law 100-360, known as the Medicare
451 Catastrophic Coverage Act of 1988, and whose income does not
452 exceed one hundred percent (100%) of the nonfarm official poverty
453 level as defined by the Office of Management and Budget and
454 revised annually.

455 The eligibility of individuals covered under this paragraph
456 shall be determined by the Division of Medicaid, and those
457 individuals determined eligible shall receive Medicare
458 cost-sharing expenses only as more fully defined by the Medicare
459 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
460 1997.

461 (13) (a) Individuals who are entitled to Medicare Part
462 A as defined in Section 4501 of the Omnibus Budget Reconciliation
463 Act of 1990, and whose income does not exceed one hundred twenty
464 percent (120%) of the nonfarm official poverty level as defined by
465 the Office of Management and Budget and revised annually.
466 Eligibility for Medicaid benefits is limited to full payment of
467 Medicare Part B premiums.

468 (b) Individuals entitled to Part A of Medicare,
469 with income above one hundred twenty percent (120%), but less than
470 one hundred thirty-five percent (135%) of the federal poverty

471 level, and not otherwise eligible for Medicaid. Eligibility for
472 Medicaid benefits is limited to full payment of Medicare Part B
473 premiums. The number of eligible individuals is limited by the
474 availability of the federal capped allocation at one hundred
475 percent (100%) of federal matching funds, as more fully defined in
476 the Balanced Budget Act of 1997.

477 The eligibility of individuals covered under this paragraph
478 shall be determined by the Division of Medicaid.

479 (14) [Deleted]

480 (15) Disabled workers who are eligible to enroll in
481 Part A Medicare as required by Public Law 101-239, known as the
482 Omnibus Budget Reconciliation Act of 1989, and whose income does
483 not exceed two hundred percent (200%) of the federal poverty level
484 as determined in accordance with the Supplemental Security Income
485 (SSI) program. The eligibility of individuals covered under this
486 paragraph shall be determined by the Division of Medicaid and
487 those individuals shall be entitled to buy-in coverage of Medicare
488 Part A premiums only under the provisions of this paragraph (15).

489 (16) In accordance with the terms and conditions of
490 approved Title XIX waiver from the United States Department of
491 Health and Human Services, persons provided home- and
492 community-based services who are physically disabled and certified
493 by the Division of Medicaid as eligible due to applying the income
494 and deeming requirements as if they were institutionalized.

495 (17) In accordance with the terms of the federal
496 Personal Responsibility and Work Opportunity Reconciliation Act of
497 1996 (Public Law 104-193), persons who become ineligible for
498 assistance under Title IV-A of the federal Social Security Act, as
499 amended, because of increased income from or hours of employment
500 of the caretaker relative or because of the expiration of the
501 applicable earned income disregards, who were eligible for
502 Medicaid for at least three (3) of the six (6) months preceding
503 the month in which the ineligibility begins, shall be eligible for
504 Medicaid for up to twelve (12) months. The eligibility of the
505 individuals covered under this paragraph shall be determined by
506 the division.

507 (18) Persons who become ineligible for assistance under
508 Title IV-A of the federal Social Security Act, as amended, as a
509 result, in whole or in part, of the collection or increased
510 collection of child or spousal support under Title IV-D of the
511 federal Social Security Act, as amended, who were eligible for
512 Medicaid for at least three (3) of the six (6) months immediately
513 preceding the month in which the ineligibility begins, shall be
514 eligible for Medicaid for an additional four (4) months beginning
515 with the month in which the ineligibility begins. The eligibility
516 of the individuals covered under this paragraph shall be
517 determined by the division.

518 (19) Disabled workers, whose incomes are above the
519 Medicaid eligibility limits, but below two hundred fifty percent

520 (250%) of the federal poverty level, shall be allowed to purchase
521 Medicaid coverage on a sliding fee scale developed by the Division
522 of Medicaid.

523 (20) Medicaid eligible children under age eighteen (18)
524 shall remain eligible for Medicaid benefits until the end of a
525 period of twelve (12) months following an eligibility
526 determination, or until such time that the individual exceeds age
527 eighteen (18).

528 (21) Women of childbearing age whose family income does
529 not exceed one hundred eighty-five percent (185%) of the federal
530 poverty level. The eligibility of individuals covered under this
531 paragraph (21) shall be determined by the Division of Medicaid,
532 and those individuals determined eligible shall only receive
533 family planning services covered under Section 43-13-117(13) and
534 not any other services covered under Medicaid. However, any
535 individual eligible under this paragraph (21) who is also eligible
536 under any other provision of this section shall receive the
537 benefits to which he or she is entitled under that other
538 provision, in addition to family planning services covered under
539 Section 43-13-117(13).

540 The Division of Medicaid shall apply to the United States
541 Secretary of Health and Human Services for a federal waiver of the
542 applicable provisions of Title XIX of the federal Social Security
543 Act, as amended, and any other applicable provisions of federal
544 law as necessary to allow for the implementation of this paragraph

545 (21). The provisions of this paragraph (21) shall be implemented
546 from and after the date that the Division of Medicaid receives the
547 federal waiver.

548 (22) Persons who are workers with a potentially severe
549 disability, as determined by the division, shall be allowed to
550 purchase Medicaid coverage. The term "worker with a potentially
551 severe disability" means a person who is at least sixteen (16)
552 years of age but under sixty-five (65) years of age, who has a
553 physical or mental impairment that is reasonably expected to cause
554 the person to become blind or disabled as defined under Section
555 1614(a) of the federal Social Security Act, as amended, if the
556 person does not receive items and services provided under
557 Medicaid.

558 The eligibility of persons under this paragraph (22) shall be
559 conducted as a demonstration project that is consistent with
560 Section 204 of the Ticket to Work and Work Incentives Improvement
561 Act of 1999, Public Law 106-170, for a certain number of persons
562 as specified by the division. The eligibility of individuals
563 covered under this paragraph (22) shall be determined by the
564 Division of Medicaid.

565 (23) Children certified by the Mississippi Department
566 of Human Services for whom the state and county departments of
567 human services have custody and financial responsibility who are
568 in foster care on their eighteenth birthday as reported by the
569 Mississippi Department of Human Services shall be certified

570 Medicaid eligible by the Division of Medicaid until their
571 twenty-first birthday.

572 (24) Individuals who have not attained age sixty-five
573 (65), are not otherwise covered by creditable coverage as defined
574 in the Public Health Services Act, and have been screened for
575 breast and cervical cancer under the Centers for Disease Control
576 and Prevention Breast and Cervical Cancer Early Detection Program
577 established under Title XV of the Public Health Service Act in
578 accordance with the requirements of that act and who need
579 treatment for breast or cervical cancer. Eligibility of
580 individuals under this paragraph (24) shall be determined by the
581 Division of Medicaid.

582 (25) The division shall apply to the Centers for
583 Medicare and Medicaid Services (CMS) for any necessary waivers to
584 provide services to individuals who are sixty-five (65) years of
585 age or older or are disabled as determined under Section
586 1614(a)(3) of the federal Social Security Act, as amended, and
587 whose income does not exceed one hundred thirty-five percent
588 (135%) of the nonfarm official poverty level as defined by the
589 Office of Management and Budget and revised annually, and whose
590 resources do not exceed those established by the Division of
591 Medicaid, and who are not otherwise covered by Medicare. Nothing
592 contained in this paragraph (25) shall entitle an individual to
593 benefits. The eligibility of individuals covered under this
594 paragraph shall be determined by the Division of Medicaid.

595 (26) The division shall apply to the Centers for
596 Medicare and Medicaid Services (CMS) for any necessary waivers to
597 provide services to individuals who are sixty-five (65) years of
598 age or older or are disabled as determined under Section
599 1614(a)(3) of the federal Social Security Act, as amended, who are
600 end stage renal disease patients on dialysis, cancer patients on
601 chemotherapy or organ transplant recipients on antirejection
602 drugs, whose income does not exceed one hundred thirty-five
603 percent (135%) of the nonfarm official poverty level as defined by
604 the Office of Management and Budget and revised annually, and
605 whose resources do not exceed those established by the division.
606 Nothing contained in this paragraph (26) shall entitle an
607 individual to benefits. The eligibility of individuals covered
608 under this paragraph shall be determined by the Division of
609 Medicaid.

610 (27) Individuals who are entitled to Medicare Part D
611 and whose income does not exceed one hundred fifty percent (150%)
612 of the nonfarm official poverty level as defined by the Office of
613 Management and Budget and revised annually. Eligibility for
614 payment of the Medicare Part D subsidy under this paragraph shall
615 be determined by the division.

616 (28) The division is authorized and directed to provide
617 up to twelve (12) months of continuous coverage postpartum for any
618 individual who qualifies for Medicaid coverage under this section

619 as a pregnant woman, to the extent allowable under federal law and
620 as determined by the division.

621 (29) Individuals described in Section (1)(a) of this
622 act. The division shall apply for a waiver of the applicable
623 provisions of the Medicaid laws and regulations under Section 1115
624 of the federal Social Security Act to create a plan to allow
625 Medicaid coverage in Mississippi in accordance with this act,
626 including a work requirement that requires beneficiaries to be
627 employed for at least one hundred twenty (120) hours per month or
628 for such beneficiary to be otherwise eligible within Section
629 (1)(a) of this act. The division shall begin enrolling eligible
630 individuals into the coverage group established in this section
631 within thirty (30) days of the effective date of CMS approving the
632 division's waiver under this section. This paragraph (29) shall
633 stand repealed on January 31, 2029. This subsection shall be
634 subject to Section 4 of this act.

635 The division shall redetermine eligibility for all categories
636 of recipients described in each paragraph of this section not less
637 frequently than required by federal law.

638 **SECTION 6.** Section 27-15-103, Mississippi Code of 1972, is
639 amended as follows:

640 27-15-103. (1) Except as otherwise provided in Section
641 83-61-11, in addition to the license tax now or hereafter provided
642 by law, which tax shall be paid when the company enters or is
643 admitted to do business in this state, there is hereby levied and

644 imposed upon all foreign insurance companies and associations,
645 including life insurance companies and associations, health,
646 accident and industrial insurance companies and associations, fire
647 and casualty insurance companies and associations, and all other
648 foreign insurance companies and associations of every kind and
649 description, an additional annual license or privilege tax of
650 three percent (3%) of the gross amount of premium receipts
651 received from, and on insurance policies and contracts written in,
652 or covering risks located in this state, except for premiums
653 received on policies issued to fund a deferred compensation plan
654 qualified under Section 457 of the Federal Tax Code for federal
655 tax exemption. In determining said amount of premiums, there
656 shall be deducted therefrom premiums received for reinsurance from
657 companies authorized to do business in this state, cash dividends
658 paid under policy contracts in this state, and premiums returned
659 to policyholders and cancellations on accounts of policies not
660 taken, and, in the case of mutual insurance companies (including
661 interinsurance and reciprocal exchanges, but not including mutual
662 life, accident, health or industrial insurance companies) any
663 refund made or credited to the policyholder other than for losses.
664 The term "premium" as used herein shall also include policy fees,
665 membership fees, and all other fees collected by the companies.
666 No credit or deduction from gross premium receipts shall be
667 allowed for any commission, fee or compensation paid to any agent,
668 solicitor or representative. Provided, however, that any foreign

669 insurance carrier selected to furnish service to the State of
670 Mississippi under the State Employees Life and Health Insurance
671 Plan shall not be required to pay the annual license or privilege
672 tax on the premiums collected for coverage under the said plan.

673 (2) In the event that the Mississippi Supreme Court or
674 another court finally adjudicates that any tax levied prior to
675 July 1, 1985, under the provisions of this section was collected
676 unconstitutionally and that a liability for a credit or refund for
677 such collection has accrued, then the rate of tax set forth above
678 shall be increased to four percent (4%) for a period of six (6)
679 years beginning July 1 following such adjudication.

680 (3) The taxes herein levied and imposed for the calendar
681 year 1982 and all calendar years thereafter shall be reduced by
682 the net amount of income tax paid to this state for the preceding
683 calendar year, provided, in no event may the credit be taken more
684 than once. The credit herein authorized shall, in no event, be
685 greater than the premium tax due under this section; it being the
686 purpose and intent of this paragraph that whichever of the annual
687 insurance premium tax or the income tax is greater in amount shall
688 be paid.

689 (4) In addition to the license tax now or hereafter provided
690 by law and the tax provided in subsection (1) of this section,
691 which tax shall be paid when the company enters or is admitted to
692 do business in this state, there is hereby levied and imposed upon
693 all foreign health insurance companies and associations that offer

694 qualified health plans to eligible beneficiaries in accordance
695 with Section 3 of this act, an additional annual license or
696 privilege tax of one percent (1%) of the gross amount of premium
697 receipts received from, and on insurance policies and contracts
698 written for, the qualified health plans provided to eligible
699 beneficiaries by such foreign health insurance companies and
700 associations in accordance with Section 3 of this act. For
701 purposes of this subsection, "premium" means a charge that must be
702 paid as a condition of enrolling in health care coverage. This
703 subsection (4) shall stand repealed on January 31, 2029. This
704 subsection (4) shall be subject to Section 4 of this act.

705 **SECTION 7.** Section 27-15-109, Mississippi Code of 1972, is
706 amended as follows:

707 27-15-109. (1) Except as otherwise provided in Section
708 83-61-11, there is hereby levied and imposed upon each domestic
709 company doing business in this state an annual tax of three
710 percent (3%) of the gross amount of premiums collected by such
711 domestic company on insurance policies and contracts written in,
712 or covering risks located in this state, except for premiums
713 received on policies issued to fund a retirement, thrift or
714 deferred compensation plan qualified under Section 401, Section
715 403 or Section 457 of the Federal Tax Code for federal tax
716 exemption. Provided, however, that a domestic insurance company
717 against which is levied additional premium tax under retaliatory
718 laws of other states in which it does business, as a result of the

719 tax increase provided by Sections 27-15-103 through 27-15-117, may
720 deduct the total of such additional retaliatory tax from the state
721 income tax due by it to the State of Mississippi. The insurance
722 carriers selected to furnish service to the State of Mississippi,
723 under the State Employees Life and Health Insurance Plan, shall
724 not be required to pay the premium tax levied against insurance
725 companies under this section on the premiums collected for
726 coverage under the state employees plan.

727 (2) Except as expressly provided by subsection (1) of this
728 section, all of the provisions of Sections 27-15-103 through
729 27-15-117 shall be applicable to such domestic insurance
730 companies. However, the statement filed with the State Tax
731 Commission by domestic insurance companies as provided in Section
732 27-15-107 shall include therein a sworn statement of all
733 additional retaliatory premium taxes paid by them to other states
734 as a result of the increase in premium taxes imposed by Sections
735 27-15-103 through 27-15-117, itemized by states to which paid.

736 (3) In the event that the Mississippi Supreme Court or
737 another court finally adjudicates that any tax levied prior to
738 July 1, 1985, under the provisions of this section was collected
739 unconstitutionally and that a liability for a credit or refund for
740 such collection has accrued, then the rate of tax set forth above
741 shall be increased to four percent (4%) for a period of six (6)
742 years beginning July 1 following such adjudication.

743 (4) In addition to the license tax now or hereafter provided
744 by law and the tax provided in subsection (1) of this section,
745 there is hereby levied and imposed upon each domestic health
746 insurance company doing business in this state that offers
747 qualified health plans to eligible beneficiaries in accordance
748 with Section 3 of this act, an additional annual license or
749 privilege tax of one percent (1%) of the gross amount of premium
750 receipts received from, and on insurance policies and contracts
751 written for, the qualified health plans provided to eligible
752 beneficiaries by such domestic health insurance companies and
753 associations in accordance with Section 3 of this act. For
754 purposes of this subsection, "premium" means a charge that must be
755 paid as a condition of enrolling in health care coverage. This
756 subsection (4) shall stand repealed on January 31, 2029. This
757 subsection (4) shall be subject to Section 4 of this act.

758 **SECTION 8.** This act shall take effect and be in force from
759 and after its passage.

**Further, amend by striking the title in its entirety and
inserting in lieu thereof the following:**

1 AN ACT TO REQUIRE THE DIVISION OF MEDICAID TO ENTER INTO
2 NEGOTIATIONS WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES
3 (CMS) TO OBTAIN A WAIVER FOR APPLICABLE PROVISIONS OF THE MEDICAID
4 LAWS AND REGULATIONS UNDER SECTION 1115 OF THE FEDERAL SOCIAL
5 SECURITY ACT TO CREATE A PLAN TO ALLOW MEDICAID COVERAGE IN
6 MISSISSIPPI FOR INDIVIDUALS WITHIN A CERTAIN COVERAGE GROUP; TO
7 PROVIDE THAT THE COVERAGE GROUP SHALL INCLUDE INDIVIDUALS WHO ARE
8 19 THROUGH 64 YEARS OF AGE WHOSE INCOME IS NOT MORE THAN 138% OF
9 THE FEDERAL POVERTY LEVEL AND ARE EMPLOYED AT LEAST 120 HOURS PER
10 MONTH IN A POSITION FOR WHICH HEALTH INSURANCE IS NOT PAID FOR BY

11 THE EMPLOYER, ARE ENROLLED AS A FULL TIME STUDENT OR IN WORKFORCE
12 TRAINING, OR ARE OTHERWISE ACTING AS A PRIMARY CAREGIVER FOR A
13 DISABLED CHILD, SPOUSE, OR PARENT; TO PROVIDE THAT ANY INDIVIDUAL
14 OTHERWISE ELIGIBLE FOR COVERAGE UNDER THE ACT WHO HAS HEALTH
15 INSURANCE COVERAGE AND VOLUNTARILY DISENROLLS SUCH COVERAGE SHALL
16 NOT BE ELIGIBLE FOR COVERAGE UNTIL 12 MONTHS AFTER THE ENDING DATE
17 OF THAT COVERAGE; TO PROHIBIT COVERAGE FOR ANY INDIVIDUAL WHO IS
18 NOT A U.S. CITIZEN; TO REQUIRE THE DIVISION TO VERIFY ELIGIBILITY
19 OF EACH BENEFICIARY NO LESS THAN ON AN ANNUAL BASIS; TO PROVIDE
20 THAT ALL INDIVIDUALS IN THE COVERAGE GROUP WHO CURRENTLY RESIDE IN
21 HOUSEHOLDS THAT HAVE AN INCOME OF LESS THAN 100% OF THE FEDERAL
22 POVERTY LEVEL SHALL BE ENROLLED IN AND THEIR SERVICES SHALL BE
23 PROVIDED BY THE MANAGED CARE ORGANIZATIONS (MCOS), COORDINATED
24 CARE ORGANIZATIONS (CCOS), PROVIDER SPONSORED HEALTH PLANS (PSHPS)
25 AND OTHER SUCH ORGANIZATIONS PAID FOR SERVICES TO THE MEDICAID
26 POPULATION ON A CAPITATED BASIS BY THE DIVISION; TO PROVIDE THAT
27 ALL INDIVIDUALS IN THE COVERAGE GROUP WHO CURRENTLY RESIDE IN
28 HOUSEHOLDS THAT HAVE AN INCOME OF AT LEAST 100% OF THE FEDERAL
29 POVERTY LEVEL BUT NOT MORE THAN 138% OF THE FEDERAL POVERTY LEVEL
30 SHALL BE ENROLLED IN AND THEIR SERVICES SHALL BE PROVIDED BY A
31 QUALIFIED HEALTH PLAN OFFERED BY AN INSURER ON THE EXCHANGE; TO
32 PROVIDE CERTAIN EXCEPTIONS; TO PROVIDE THAT INDIVIDUALS ENROLLED
33 UNDER THIS ACT SHALL BE PROVIDED ESSENTIAL HEALTH SERVICES AS
34 DETERMINED BY THE DIVISION, WHICH SHALL, AT A MINIMUM, INCLUDE
35 AMBULATORY PATIENT SERVICES, EMERGENCY SERVICES, HOSPITALIZATION,
36 PRESCRIPTION DRUGS, REHABILITATIVE SERVICES, LABORATORY SERVICES,
37 PRIMARY CARE SERVICES AND PREVENTIVE AND WELLNESS SERVICES AND
38 CHRONIC DISEASE MANAGEMENT; TO PROVIDE FOR THE FUNDING OF THE
39 PLAN; TO PROVIDE FOR THE LEVY OF AN ASSESSMENT UPON EACH MANAGED
40 CARE ORGANIZATION, COORDINATED CARE ORGANIZATION, PROVIDER
41 SPONSORED HEALTH PLAN OR OTHER ORGANIZATION PAID FOR SERVICES ON A
42 CAPITATED BASIS BY THE DIVISION, IN THE AMOUNT OF 3% ON THE TOTAL
43 PAID CAPITATION; TO CREATE IN THE STATE TREASURY A SPECIAL FUND TO
44 BE KNOWN AS THE "MEDICAID BENEFICIARIES COVERAGE SPECIAL FUND,"
45 FOR THE PURPOSE OF PROVIDING THE STATE'S SHARE OF FUNDING THE PLAN
46 PROVIDED IN THIS ACT; TO REQUIRE THE DIVISION TO APPLY FOR A
47 WAIVER OF THE APPLICABLE PROVISIONS OF THE MEDICAID LAWS WITHIN
48 120 DAYS OF THE EFFECTIVE DATE OF THE ACT; TO PROVIDE THAT IF CMS
49 REJECTS THE DIVISION'S WORK REQUIREMENT WAIVER REQUEST, THEN THIS
50 ACT SHALL STAND REPEALED ON THE DATE OF SUCH REJECTION; TO PROVIDE
51 OTHER CONDITIONS BY WHICH THE ACT MAY BE REPEALED; TO AMEND
52 SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE
53 PROVISIONS OF THE ACT; TO AMEND SECTIONS 27-15-103 AND 27-15-109,
54 MISSISSIPPI CODE OF 1972, TO PROVIDE AN ADDITIONAL ANNUAL LICENSE
55 OR PRIVILEGE TAX OF 1% OF THE GROSS AMOUNT OF PREMIUM RECEIPTS
56 RECEIVED FROM, AND ON INSURANCE POLICIES AND CONTRACTS WRITTEN
57 FOR, THE QUALIFIED HEALTH PLANS PROVIDED TO ELIGIBLE BENEFICIARIES
58 BY FOREIGN AND DOMESTIC HEALTH INSURANCE COMPANIES AND
59 ASSOCIATIONS DOING BUSINESS IN THIS STATE THAT OFFER QUALIFIED

60 HEALTH PLANS TO ELIGIBLE BENEFICIARIES IN ACCORDANCE WITH THIS
61 ACT; AND FOR RELATED PURPOSES.

CONFEREES FOR THE HOUSE

Missy McGee

Sam Creekmore IV

Joey Hood

CONFEREES FOR THE SENATE



Kevin Blackwell



Nicole Boyd



Eric Wiggins