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:

61 **SECTION 1.** (1) The Office of the Governor, Division of
62 Medicaid, shall enter into negotiations with the Centers for
63 Medicare and Medicaid Services (CMS) to obtain a waiver for
64 applicable provisions of the Medicaid laws and regulations under
65 Section 1115 of the federal Social Security Act to create a plan
66 to allow Medicaid coverage in Mississippi for individuals
67 described in this act, which contains the following provisions:
68 (a) Coverage group. Individuals eligible for coverage
69 under this section shall be persons who are not less than nineteen
70 (19) years of age but less than sixty-five (65) years of age, who
71 currently reside in households that have an income of not more
72 than one hundred thirty-eight percent (138%) of the federal

73 poverty level, and to the extent approved by CMS in the Section
74 1115 waiver, who are:
75 (i) Employed for at least one hundred (100) hours
76 per month in a position for which health insurance is not paid for
77 by the employer;
78 (ii) Enrolled as a full-time student in secondary
79 or post-secondary education;
80 (iii) Enrolled full-time in a workforce training
81 program;
82 (iv) Enrolled for at least six (6) credit hours,
83 or its equivalent, as a student in secondary education,
84 post-secondary education, or a workforce training program and is
85 employed for at least sixty (60) hours per month in a position for
86 which health insurance is not paid for by the employer;
87 (v) The parent or guardian and the primary
88 caregiver of a child under six (6) years of age;
89 (vi) A person who is physically, mentally or
90 intellectually unable to meet the requirements of subparagraphs
91 (i) through (iv) of this paragraph (a) as documented by a medical
92 professional; or
93 (vii) The primary caregiver for a disabled child,
94 spouse or parent, provided that such disabled person qualifies for
95 Medicaid coverage in accordance with the federal Social Security
96 Act.

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

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

122 Mississippi are aware of and have the opportunity to apply for
123 eligibility.
124 (c) Delivery systems.
125 (i) All individuals in the coverage group who
126 currently reside in households that have an income of less than
127 one hundred percent (100%) of the federal poverty level shall be
128 enrolled in and their services shall be provided by the managed
129 care organizations (MCOs), coordinated care organizations (CCOs),
130 provider-sponsored health plans (PSHPs) and other such
131 organizations paid for services to the Medicaid population on a
132 capitated basis by the division as described in Section
133 43-13-117(H).
134 (ii) All individuals in the coverage group who
135 currently reside in households that have an income of at least one
136 hundred percent (100%) of the federal poverty level but not more
137 than one hundred thirty-eight percent (138%) of the federal
138 poverty level shall be enrolled in and their services shall be
139 provided by a qualified health plan in accordance with Section 3
140 of this act. Any individual who meets the income thresholds of
141 this subparagraph (ii), but is deemed medically frail by the
142 Division, may be enrolled in and their services shall be provided
143 by a managed care organizations (MCOs), coordinated care
144 organizations (CCOs), provider sponsored health plans (PSHPs) and
145 other such organizations paid for services to the Medicaid
146 population on a capitated basis by the division as described in

147 Section 43-13-117(H), or through the division's fee-for-service
148 program.
149 (d) Benefit packages. Individuals enrolled under this
150 act who are not less than nineteen (19) years of age but less than
151 sixty five (65) years of age shall be provided essential health
152 services as determined by the division, which shall, at a minimum,
153 include ambulatory patient services, emergency services,
154 hospitalization, prescription drugs, rehabilitative services,
155 laboratory services, primary care services, preventive and
156 wellness services and chronic disease management.
157 (e) Funding of the plan.
158 (i) The Section 1115 waiver described in this
159 section shall describe the funding for this act, which shall be a
160 combination of state matching funds and federal matching funds in
161 the proportions specified under the federal Affordable Care Act at
162 the time of the effective date of this act.
163 (ii) The state matching funds shall include
164 contributions from MCOs, CCOs, PSHPs and other such organizations
165 paid for services to the Medicaid population on a capitated basis
166 by the division as described in Section 43-13-117(H) in the form
167 of an assessment as provided in Section 2 of this act and all
168 other revenue sources as provided in this act. The state matching
169 funds shall also include contributions from hospitals that are
170 generated through an assessment on hospitals as described in

171 Section 43-13-145 and deposited into the Medical Care Fund created
172 in Section 43-13-143.
173 (iii) The division is also authorized to accept
174 any voluntary contributions donated to the division to be used as
175 state matching funds for the purpose of this act, including, but
176 not limited to, contributions from businesses and other entities.
177 (iv) If the funds derived from subparagraphs (ii)
178 through (iii) of this paragraph and Sections 27-15-103 (4) and
179 27-15-109 (4) are lower than the amount needed to account for the
180 state's matching funds, funds derived from the three percent (3%)
181 taxes levied in Sections 27-15-103 and 27-15-109 shall be diverted
182 to account for the state's matching funds. Notwithstanding any
183 provision of this paragraph (e), state matching funds for the
184 purposes of this act may also be appropriated by the Legislature
185 from any other sources.
186 (f) Timing. Within one hundred twenty (120) days of
187 the effective date of this act, the division shall apply for a
188 waiver of the applicable provisions of the Medicaid laws and
189 regulations under Section 1115 of the federal Social Security Act
190 to create a plan to allow Medicaid coverage in Mississippi in
191 accordance with this act, which shall include a work requirement
192 that requires beneficiaries to be employed for at least one
193 hundred (100) hours per month or for such beneficiary to be
194 otherwise eligible within paragraph (a) of this subsection. The
195 division shall provide a copy of such application to the Governor,

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

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

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

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

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

210 **SECTION 2.** (1) Notwithstanding any other provision of law,
211 upon each managed care organization, coordinated care
212 organization, provider sponsored health plan or other organization
213 paid for services to the Medicaid population on a capitated basis
214 by the Division of Medicaid as described in Section 43-13-117(H),
215 there is levied an assessment of three percent (3%) on the total
216 paid capitation. All assessments under this section shall be
217 assessed and collected by the division on the 15th of each month
218 and shall be deposited into the Medicaid Beneficiaries Coverage
219 Special Fund created by subsection (2) of this section. Any
220 amount generated by the assessment that is in excess of the amount

221 needed to cover the state matching funds may be used to enhance
222 provider reimbursement for those services that are most utilized
223 by the coverage group as determined by the division. This section
224 shall be effective in the first month that a capitated payment is
225 provided to a managed care organization, coordinated care
226 organization, provider sponsored health plan or other organization
227 paid for services to the Medicaid population on a capitated basis
228 by the division as described in Section 43-13-117(H) for coverage
229 of individuals eligible under Section 1 of this act and Section
230 43-13-115. The Division of Medicaid is directed to apply for any
231 applicable federal waiver to accomplish the purposes of this
232 section.
233 (2) There is created in the State Treasury a special fund to
234 be known as the "Medicaid Beneficiaries Coverage Special Fund,"
235 for the purpose of providing the state's share of funding the plan
236 provided in this act. The fund shall be comprised of monies
237 collected from the following sources:
238 (a) The assessment provided in subsection (1) of this
239 section;
240 (b) The assessment provided in Section 27-15-103(4);
241 (c) The assessment provided in Section 27-15-109(4);
242 and
243 (d) Any amounts provided from CMS as the federal
244 matching fund proportion for medical services provided to the
245 coverage group.

246 (3) Unexpended monies remaining in the Medicaid
247 Beneficiaries Coverage Special Fund at the end of a fiscal year
248 shall not lapse into the State General Fund, and any interest
249 earned on monies in the fund shall be deposited to the credit of
250 the fund.

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

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

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

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

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

260 (i) Are in the coverage group provided in Section
261 1(a) of this act and who currently reside in households that have
262 an income of at least one hundred percent (100%) of the federal
263 poverty level but not more than one hundred thirty-eight percent
264 (138%) of the federal poverty level; and

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

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

271 (d) "Insurer" means any entity that provides or offers
272 a qualified health plan.
273 (c) "Premium" means a charge that must be paid as a
274 condition of enrolling in health care coverage.
275 (c) "Qualified health plan" means a State Insurance
276 Department certified individual health insurance plan offered by
277 an insurer through the exchange.
278 (2) All eligible beneficiaries under this section shall be
279 offered health coverage through a qualified health plan offered by
280 an insurer through the exchange. The division shall ensure only
281 the most cost-effective plans are offered to eligible
282 beneficiaries.
283 (3) The division shall pay the state's matching fund
284 proportion that is needed to cover the premiums and cost-sharing
285 of any qualified health plan provided to an eligible beneficiary.
286 (4) If a state-based exchange is implemented after the
287 effective date of this act, then all eligible beneficiaries shall
288 be transitioned to qualified health plans offered on the
289 state-based exchange.
290 (5) This section shall stand repealed on January 31, 2029.
291 (6) This section shall be subject to Section 4 of this act.
292 **SECTION 4.** (1) Sections 1 through 4 of this act and
293 Sections 43-13-115(29), 27-15-103(4) and 27-15-109(4) shall stand
294 repealed on the date of any of the following:

295 (a) On such date that the Centers for Medicare and
296 Medicaid Services (CMS) reject the assessments provided for in
297 this act;
298 (b) On such date that the Centers for Medicare and
299 Medicaid Services (CMS) withdraws approval of, cancels or
300 constructively terminates any waiver that was previously issued to
301 the division as a condition of the requirements of this act;
302 (c) On such date that a court of competent jurisdiction
303 nullifies the work requirement provided for in Section 1 of this
304 act;
305 (d) On such date that a court of competent jurisdiction
306 nullifies the assessments provided for in this act; or
307 (e) On such date that the federal matching fund
308 proportion for medical services provided to the coverage group
309 ever falls below ninety percent (90%), or as close to that date as
310 required in order for the division to comply with any federal
311 notice and due process requirements.
312 (2) If the division receives a waiver in accordance with
313 this act, but the act is later repealed through any of the events
314 or actions listed in subsection (1) of this section, then the
315 division shall have ninety (90) days to cease coverage of eligible
316 individuals under this act and to provide notice to such
317 individuals of the termination of coverage.
318 (3) If the Centers for Medicare and Medicaid Services (CMS)
319 reject the division's work requirement waiver request provided for

320 in Section 1 of this act, then the provisions of this act shall be
321 suspended indefinitely; provided, however, that if CMS
322 subsequently approves another state's work requirement waiver
323 request, then the division shall reapply for the applicable
324 waivers needed to fulfill the provisions of this act within thirty
325 (30) days of the date that CMS approved any such waiver.

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

328 43-13-115. Recipients of Medicaid shall be the following
329 persons only:

330 (1) Those who are qualified for public assistance
331 grants under provisions of Title IV-A and E of the federal Social
332 Security Act, as amended, including those statutorily deemed to be
333 IV-A and low income families and children under Section 1931 of
334 the federal Social Security Act. For the purposes of this
335 paragraph (1) and paragraphs (8), (17) and (18) of this section,
336 any reference to Title IV-A or to Part A of Title IV of the
337 federal Social Security Act, as amended, or the state plan under
338 Title IV-A or Part A of Title IV, shall be considered as a
339 reference to Title IV-A of the federal Social Security Act, as
340 amended, and the state plan under Title IV-A, including the income
341 and resource standards and methodologies under Title IV-A and the
342 state plan, as they existed on July 16, 1996. The Department of
343 Human Services shall determine Medicaid eligibility for children
344 receiving public assistance grants under Title IV-E. The division

345 shall determine eligibility for low income families under Section
346 1931 of the federal Social Security Act and shall redetermine
347 eligibility for those continuing under Title IV-A grants.
348 (2) Those qualified for Supplemental Security Income
349 (SSI) benefits under Title XVI of the federal Social Security Act,
350 as amended, and those who are deemed SSI eligible as contained in
351 federal statute. The eligibility of individuals covered in this
352 paragraph shall be determined by the Social Security
353 Administration and certified to the Division of Medicaid.
354 (3) Qualified pregnant women who would be eligible for
355 Medicaid as a low income family member under Section 1931 of the
356 federal Social Security Act if her child were born. The
357 eligibility of the individuals covered under this paragraph shall
358 be determined by the division.
359 (4) [Deleted]
360 (5) A child born on or after October 1, 1984, to a
361 woman eligible for and receiving Medicaid under the state plan on
362 the date of the child's birth shall be deemed to have applied for
363 Medicaid and to have been found eligible for Medicaid under the
364 plan on the date of that birth, and will remain eligible for
365 Medicaid for a period of one (1) year so long as the child is a
366 member of the woman's household and the woman remains eligible for
367 Medicaid or would be eligible for Medicaid if pregnant. The
368 eligibility of individuals covered in this paragraph shall be
369 determined by the Division of Medicaid.

370 (6) Children certified by the State Department of Human
371 Services to the Division of Medicaid of whom the state and county
372 departments of human services have custody and financial
373 responsibility, and children who are in adoptions subsidized in
374 full or part by the Department of Human Services, including
375 special needs children in non-Title IV-E adoption assistance, who
376 are approvable under Title XIX of the Medicaid program. The
377 eligibility of the children covered under this paragraph shall be
378 determined by the State Department of Human Services.
379 (7) Persons certified by the Division of Medicaid who
380 are patients in a medical facility (nursing home, hospital,
381 tuberculosis sanatorium or institution for treatment of mental
382 diseases), and who, except for the fact that they are patients in
383 that medical facility, would qualify for grants under Title IV,
384 Supplementary Security Income (SSI) benefits under Title XVI or
385 state supplements, and those aged, blind and disabled persons who
386 would not be eligible for Supplemental Security Income (SSI)
387 benefits under Title XVI or state supplements if they were not
388 institutionalized in a medical facility but whose income is below
389 the maximum standard set by the Division of Medicaid, which
390 standard shall not exceed that prescribed by federal regulation.
391 (8) Children under eighteen (18) years of age and
392 pregnant women (including those in intact families) who meet the
393 financial standards of the state plan approved under Title IV-A of
394 the federal Social Security Act, as amended. The eligibility of

395 children covered under this paragraph shall be determined by the
396 Division of Medicaid.
397 (9) Individuals who are:
398 (a) Children born after September 30, 1983, who
399 have not attained the age of nineteen (19), with family income
400 that does not exceed one hundred percent (100%) of the nonfarm
401 official poverty level;
402 (b) Pregnant women, infants and children who have
403 not attained the age of six (6), with family income that does not
404 exceed one hundred thirty-three percent (133%) of the federal
405 poverty level; and
406 (c) Pregnant women and infants who have not
407 attained the age of one (1), with family income that does not
408 exceed one hundred eighty-five percent (185%) of the federal
409 poverty level.
410 The eligibility of individuals covered in (a), (b) and (c) of
411 this paragraph shall be determined by the division.
412 (10) Certain disabled children age eighteen (18) or
413 under who are living at home, who would be eligible, if in a
414 medical institution, for SSI or a state supplemental payment under
415 Title XVI of the federal Social Security Act, as amended, and
416 therefore for Medicaid under the plan, and for whom the state has
417 made a determination as required under Section 1902(e)(3)(b) of
418 the federal Social Security Act, as amended. The eligibility of

419 individuals under this paragraph shall be determined by the
420 Division of Medicaid.
421 (11) Until the end of the day on December 31, 2005,
422 individuals who are sixty-five (65) years of age or older or are
423 disabled as determined under Section 1614(a)(3) of the federal
424 Social Security Act, as amended, and whose income does not exceed
425 one hundred thirty-five percent (135%) of the nonfarm official
426 poverty level as defined by the Office of Management and Budget
427 and revised annually, and whose resources do not exceed those
428 established by the Division of Medicaid. The eligibility of
429 individuals covered under this paragraph shall be determined by
430 the Division of Medicaid. After December 31, 2005, only those
431 individuals covered under the 1115(c) Healthier Mississippi waiver
432 will be covered under this category.
433 Any individual who applied for Medicaid during the period
434 from July 1, 2004, through March 31, 2005, who otherwise would
435 have been eligible for coverage under this paragraph (11) if it
436 had been in effect at the time the individual submitted his or her
437 application and is still eligible for coverage under this
438 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
439 coverage under this paragraph (11) from March 31, 2005, through
440 December 31, 2005. The division shall give priority in processing
441 the applications for those individuals to determine their
442 eligibility under this paragraph (11).

443 (12) Individuals who are qualified Medicare
444 beneficiaries (QMB) entitled to Part A Medicare as defined under
445 Section 301, Public Law 100-360, known as the Medicare
446 Catastrophic Coverage Act of 1988, and whose income does not
447 exceed one hundred percent (100%) of the nonfarm official poverty
448 level as defined by the Office of Management and Budget and
449 revised annually.
450 The eligibility of individuals covered under this paragraph
451 shall be determined by the Division of Medicaid, and those
452 individuals determined eligible shall receive Medicare
453 cost-sharing expenses only as more fully defined by the Medicare
454 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
455 1997.
456 (13) (a) Individuals who are entitled to Medicare Part
457 A as defined in Section 4501 of the Omnibus Budget Reconciliation
458 Act of 1990, and whose income does not exceed one hundred twenty
459 percent (120%) of the nonfarm official poverty level as defined by
460 the Office of Management and Budget and revised annually.
461 Eligibility for Medicaid benefits is limited to full payment of
462 Medicare Part B premiums.
463 (b) Individuals entitled to Part A of Medicare,
464 with income above one hundred twenty percent (120%), but less than
465 one hundred thirty-five percent (135%) of the federal poverty
466 level, and not otherwise eligible for Medicaid. Eligibility for
467 Medicaid benefits is limited to full payment of Medicare Part B

468 premiums. The number of eligible individuals is limited by the
469 availability of the federal capped allocation at one hundred
470 percent (100%) of federal matching funds, as more fully defined in
471 the Balanced Budget Act of 1997.
472 The eligibility of individuals covered under this paragraph
473 shall be determined by the Division of Medicaid.
474 (14) [Deleted]
475 (15) Disabled workers who are eligible to enroll in
476 Part A Medicare as required by Public Law 101-239, known as the
477 Omnibus Budget Reconciliation Act of 1989, and whose income does
478 not exceed two hundred percent (200%) of the federal poverty level
479 as determined in accordance with the Supplemental Security Income
480 (SSI) program. The eligibility of individuals covered under this
481 paragraph shall be determined by the Division of Medicaid and
482 those individuals shall be entitled to buy-in coverage of Medicare
483 Part A premiums only under the provisions of this paragraph (15).
484 (16) In accordance with the terms and conditions of
485 approved Title XIX waiver from the United States Department of
486 Health and Human Services, persons provided home- and
487 community-based services who are physically disabled and certified
488 by the Division of Medicaid as eligible due to applying the income
489 and deeming requirements as if they were institutionalized.
490 (17) In accordance with the terms of the federal
491 Personal Responsibility and Work Opportunity Reconciliation Act of
492 1996 (Public Law 104-193), persons who become ineligible for

493 assistance under Title IV-A of the federal Social Security Act, as
494 amended, because of increased income from or hours of employment
495 of the caretaker relative or because of the expiration of the
496 applicable earned income disregards, who were eligible for
497 Medicaid for at least three (3) of the six (6) months preceding
498 the month in which the ineligibility begins, shall be eligible for
499 Medicaid for up to twelve (12) months. The eligibility of the
500 individuals covered under this paragraph shall be determined by
501 the division.
502 (18) Persons who become ineligible for assistance under
503 Title IV-A of the federal Social Security Act, as amended, as a
504 result, in whole or in part, of the collection or increased
505 collection of child or spousal support under Title IV-D of the
506 federal Social Security Act, as amended, who were eligible for
507 Medicaid for at least three (3) of the six (6) months immediately
508 preceding the month in which the ineligibility begins, shall be
509 eligible for Medicaid for an additional four (4) months beginning
510 with the month in which the ineligibility begins. The eligibility
511 of the individuals covered under this paragraph shall be
512 determined by the division.
513 (19) Disabled workers, whose incomes are above the
514 Medicaid eligibility limits, but below two hundred fifty percent
515 (250%) of the federal poverty level, shall be allowed to purchase
516 Medicaid coverage on a sliding fee scale developed by the Division
517 of Medicaid.

518 (20) Medicaid eligible children under age eighteen (18)
519 shall remain eligible for Medicaid benefits until the end of a
520 period of twelve (12) months following an eligibility
521 determination, or until such time that the individual exceeds age
522 eighteen (18).
523 (21) Women of childbearing age whose family income does
524 not exceed one hundred eighty-five percent (185%) of the federal
525 poverty level. The eligibility of individuals covered under this
526 paragraph (21) shall be determined by the Division of Medicaid,
527 and those individuals determined eligible shall only receive
528 family planning services covered under Section 43-13-117(13) and
529 not any other services covered under Medicaid. However, any
530 individual eligible under this paragraph (21) who is also eligible
531 under any other provision of this section shall receive the
532 benefits to which he or she is entitled under that other
533 provision, in addition to family planning services covered under
534 Section 43-13-117(13).
535 The Division of Medicaid shall apply to the United States
536 Secretary of Health and Human Services for a federal waiver of the
537 applicable provisions of Title XIX of the federal Social Security
538 Act, as amended, and any other applicable provisions of federal
539 law as necessary to allow for the implementation of this paragraph
540 (21). The provisions of this paragraph (21) shall be implemented
541 from and after the date that the Division of Medicaid receives the
542 federal waiver.

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

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

560 (23) Children certified by the Mississippi Department
561 of Human Services for whom the state and county departments of
562 human services have custody and financial responsibility who are
563 in foster care on their eighteenth birthday as reported by the
564 Mississippi Department of Human Services shall be certified
565 Medicaid eligible by the Division of Medicaid until their
566 twenty-first birthday.

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

577 (25) The division shall apply to the Centers for
578 Medicare and Medicaid Services (CMS) for any necessary waivers to
579 provide services to individuals who are sixty-five (65) years of
580 age or older or are disabled as determined under Section
581 1614(a)(3) of the federal Social Security Act, as amended, and
582 whose income does not exceed one hundred thirty-five percent
583 (135%) of the nonfarm official poverty level as defined by the
584 Office of Management and Budget and revised annually, and whose
585 resources do not exceed those established by the Division of
586 Medicaid, and who are not otherwise covered by Medicare. Nothing
587 contained in this paragraph (25) shall entitle an individual to
588 benefits. The eligibility of individuals covered under this
589 paragraph shall be determined by the Division of Medicaid.

590 (26) The division shall apply to the Centers for
591 Medicare and Medicaid Services (CMS) for any necessary waivers to

592 provide services to individuals who are sixty-five (65) years of
593 age or older or are disabled as determined under Section
594 1614(a)(3) of the federal Social Security Act, as amended, who are
595 end stage renal disease patients on dialysis, cancer patients on
596 chemotherapy or organ transplant recipients on antirejection
597 drugs, whose income does not exceed one hundred thirty-five
598 percent (135%) of the nonfarm official poverty level as defined by
599 the Office of Management and Budget and revised annually, and
600 whose resources do not exceed those established by the division.
601 Nothing contained in this paragraph (26) shall entitle an
602 individual to benefits. The eligibility of individuals covered
603 under this paragraph shall be determined by the Division of
604 Medicaid.

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

611 (28) The division is authorized and directed to provide
612 up to twelve (12) months of continuous coverage postpartum for any
613 individual who qualifies for Medicaid coverage under this section
614 as a pregnant woman, to the extent allowable under federal law and
615 as determined by the division.

616 (29) Individuals described in Section (1)(a) of this
617 act. The division shall apply for a waiver of the applicable
618 provisions of the Medicaid laws and regulations under Section 1115
619 of the federal Social Security Act to create a plan to allow
620 Medicaid coverage in Mississippi in accordance with this act,
621 including a work requirement that requires beneficiaries to be
622 employed for at least one hundred (100) hours per month or for
623 such beneficiary to be otherwise eligible within Section (1)(a) of
624 this act. The division shall begin enrolling eligible individuals
625 into the coverage group established in this section within thirty
626 (30) days of the effective date of CMS approving the division's
627 waiver under this section. This paragraph (29) shall stand
628 repealed on January 31, 2029. This subsection shall be subject to
629 Section 4 of this act.

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

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

635 27-15-103. (1) Except as otherwise provided in Section
636 83-61-11, in addition to the license tax now or hereafter provided
637 by law, which tax shall be paid when the company enters or is
638 admitted to do business in this state, there is hereby levied and
639 imposed upon all foreign insurance companies and associations,
640 including life insurance companies and associations, health,

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

666 Plan shall not be required to pay the annual license or privilege
667 tax on the premiums collected for coverage under the said plan.
668 (2) In the event that the Mississippi Supreme Court or
669 another court finally adjudicates that any tax levied prior to
670 July 1, 1985, under the provisions of this section was collected
671 unconstitutionally and that a liability for a credit or refund for
672 such collection has accrued, then the rate of tax set forth above
673 shall be increased to four percent (4%) for a period of six (6)
674 years beginning July 1 following such adjudication.
675 (3) The taxes herein levied and imposed for the calendar
676 year 1982 and all calendar years thereafter shall be reduced by
677 the net amount of income tax paid to this state for the preceding
678 calendar year, provided, in no event may the credit be taken more
679 than once. The credit herein authorized shall, in no event, be
680 greater than the premium tax due under this section; it being the
681 purpose and intent of this paragraph that whichever of the annual
682 insurance premium tax or the income tax is greater in amount shall
683 be paid.
684 (4) In addition to the license tax now or hereafter provided
685 by law and the tax provided in subsection (1) of this section,
686 which tax shall be paid when the company enters or is admitted to
687 do business in this state, there is hereby levied and imposed upon
688 all foreign health insurance companies and associations that offer
689 qualified health plans to eligible beneficiaries in accordance
690 with Section 3 of this act, an additional annual license or

691 privilege tax of one percent (1%) of the gross amount of premium
692 receipts received from, and on insurance policies and contracts
693 written for, the qualified health plans provided to eligible
694 beneficiaries by such foreign health insurance companies and
695 associations in accordance with Section 3 of this act. For
696 purposes of this subsection, "premium" means a charge that must be
697 paid as a condition of enrolling in health care coverage. This
698 subsection (4) shall stand repealed on January 31, 2029. This
699 subsection (4) shall be subject to Section 4 of this act.
700 **SECTION 7.** Section 27-15-109, Mississippi Code of 1972, is
701 amended as follows:
702 27-15-109. (1) Except as otherwise provided in Section
703 83-61-11, there is hereby levied and imposed upon each domestic
704 company doing business in this state an annual tax of three
705 percent (3%) of the gross amount of premiums collected by such
706 domestic company on insurance policies and contracts written in,
707 or covering risks located in this state, except for premiums
708 received on policies issued to fund a retirement, thrift or
709 deferred compensation plan qualified under Section 401, Section
710 403 or Section 457 of the Federal Tax Code for federal tax
711 exemption. Provided, however, that a domestic insurance company
712 against which is levied additional premium tax under retaliatory
713 laws of other states in which it does business, as a result of the
714 tax increase provided by Sections 27-15-103 through 27-15-117, may
715 deduct the total of such additional retaliatory tax from the state

716 income tax due by it to the State of Mississippi. The insurance
717 carriers selected to furnish service to the State of Mississippi,
718 under the State Employees Life and Health Insurance Plan, shall
719 not be required to pay the premium tax levied against insurance
720 companies under this section on the premiums collected for
721 coverage under the state employees plan.

722 (2) Except as expressly provided by subsection (1) of this
723 section, all of the provisions of Sections 27-15-103 through
724 27-15-117 shall be applicable to such domestic insurance
725 companies. However, the statement filed with the State Tax
726 Commission by domestic insurance companies as provided in Section
727 27-15-107 shall include therein a sworn statement of all
728 additional retaliatory premium taxes paid by them to other states
729 as a result of the increase in premium taxes imposed by Sections
730 27-15-103 through 27-15-117, itemized by states to which paid.

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

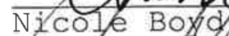
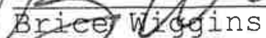
738 <u>(4) In addition to the license tax now or hereafter provided</u>
739 <u>by law and the tax provided in subsection (1) of this section,</u>
740 <u>there is hereby levied and imposed upon each domestic health</u>

741 insurance company doing business in this state that offers
742 qualified health plans to eligible beneficiaries in accordance
743 with Section 3 of this act, an additional annual license or
744 privilege tax of one percent (1%) of the gross amount of premium
745 receipts received from, and on insurance policies and contracts
746 written for, the qualified health plans provided to eligible
747 beneficiaries by such domestic health insurance companies and
748 associations in accordance with Section 3 of this act. For
749 purposes of this subsection, "premium" means a charge that must be
750 paid as a condition of enrolling in health care coverage. This
751 subsection (4) shall stand repealed on January 31, 2029. This
752 subsection (4) shall be subject to Section 4 of this act.
753 **SECTION 8.** This act shall take effect and be in force from
754 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 100 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 CERTAIN
49 CONDITIONS BY WHICH THE ACT MAY BE REPEALED; TO AMEND SECTION
50 43-13-115, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PROVISIONS
51 OF THE ACT; TO AMEND SECTIONS 27-15-103 AND 27-15-109, MISSISSIPPI
52 CODE OF 1972, TO PROVIDE AN ADDITIONAL ANNUAL LICENSE OR PRIVILEGE
53 TAX OF 1% OF THE GROSS AMOUNT OF PREMIUM RECEIPTS RECEIVED FROM,
54 AND ON INSURANCE POLICIES AND CONTRACTS WRITTEN FOR, THE QUALIFIED
55 HEALTH PLANS PROVIDED TO ELIGIBLE BENEFICIARIES BY FOREIGN AND
56 DOMESTIC HEALTH INSURANCE COMPANIES AND ASSOCIATIONS DOING
57 BUSINESS IN THIS STATE THAT OFFER QUALIFIED HEALTH PLANS TO
58 ELIGIBLE BENEFICIARIES IN ACCORDANCE WITH THIS ACT; AND FOR
59 RELATED PURPOSES.

CONFEREES FOR THE HOUSE	CONFEREES FOR THE SENATE
Missy McGee	Kevin Blackwell
Sam Creekmore IV	 Nicole Boyd
Joey Hood	 Brice Wiggins