AN ACT RELATING TO HEALTH CARE; TO ENACT THE "MISSISSIPPI HEALTH CARE REFORM ACT OF 2009"; ESTABLISHING A STATEWIDE HEALTH IMPROVEMENT GRANT PROGRAM IN THE OFFICE OF TOBACCO CONTROL OF THE STATE DEPARTMENT OF HEALTH; ESTABLISHING HEALTH CARE HOMES AND REPORTING REQUIREMENTS AS A REQUIRED SERVICE WITHIN THE MISSISSIPPI MEDICAID PROGRAM, THE S.C.H.I.P. PROGRAM, THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE PLAN, AND CAFETERIA HEALTH PLANS OFFERED BY PUBLIC ENTITIES; ESTABLISHING A CARE COORDINATION PAYMENT; REQUIRING A WORKFORCE SHORTAGE STUDY; ESTABLISHING REQUIREMENTS FOR INTEROPERABLE HEALTH RECORDS; ESTABLISHING ELECTRONIC PRESCRIPTION DRUG PROGRAM; REQUIRING RECOMM Endings FOR AN ESSENTIAL BENEFIT SET FOR HEALTH BENEFITS; PROVIDING FOR HEALTH CARE PAYMENT Restructuring BY THE COMMISSIONER OF INSURANCE; REQUIRING UNIFORM STANDARDS; ESTABLISHING A HEALTH CARE REFORM REVIEW COUNCIL; ESTABLISHING SECTION 125 PLAN REQUIREMENT; REQUIRING REPORTS; TO AMEND SECTIONS 41-113-3, 41-86-3 AND 41-86-5, MISSISSIPPI CODE OF 1972, IN CONFORMITY THERETO; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. This act shall be known and may be cited as the "Mississippi Health Care Reform Act of 2009."

SECTION 2. Section 41-113-3, Mississippi Code of 1972, is amended as follows:

41-113-3. (1) There is hereby created the Office of Tobacco Control (office) which shall be an administrative division of the State Department of Health.

(2) The Office of Tobacco Control, with the advice of the Mississippi Tobacco Control Advisory Board, shall develop and implement a comprehensive and statewide tobacco education, prevention and cessation program that is consistent with the recommendations for effective program components and funding recommendations in the 1999 Best Practices for Comprehensive Tobacco Control Programs of the federal Centers for Disease Control and Prevention, as those Best Practices may be
periodically amended by the Centers for Disease Control and Prevention.

(3) At a minimum, the program shall include the following components, and may include additional components that are contained within the Best Practices for Comprehensive Tobacco Control Programs of the federal Centers for Disease Control and Prevention, as periodically amended, and that based on scientific data and research have been shown to be effective at accomplishing the purposes of this section:

(a) The use of mass media, including paid advertising and other communication tools to discourage the use of tobacco products and to educate people, especially youth, about the health hazards from the use of tobacco products, which shall be designed to be effective at achieving these goals and shall include, but need not be limited to, television, radio, and print advertising, as well as sponsorship, exhibits and other opportunities to raise awareness statewide;

(b) Evidence-based curricula and programs implemented in schools to educate youth about tobacco and to discourage their use of tobacco products, including, but not limited to, programs that involve youth, educate youth about the health hazards from the use of tobacco products, help youth develop skills to refuse tobacco products, and demonstrate to youth how to stop using tobacco products;

(c) Local community programs, including, but not limited to, youth-based partnerships that discourage the use of tobacco products and involve community-based organizations in tobacco education, prevention and cessation programs in their communities;

(d) Enforcement of laws, regulations and policies against the sale or other provision of tobacco products to minors, and the possession of tobacco products by minors;
(e) Programs to assist and help people to stop using tobacco products; and

(f) A surveillance and evaluation system that monitors program accountability and results, produces publicly available reports that review how monies expended for the program are spent, and includes an evaluation of the program's effectiveness in reducing and preventing the use of tobacco products, and annual recommendations for improvements to enhance the program's effectiveness.

(4) All programs or activities funded by the State Department of Health through the tobacco education, prevention and cessation program, whether part of a component described in subsection (2) or an additional component, must be consistent with the Best Practices for Comprehensive Tobacco Control Programs of the federal Centers for Disease Control and Prevention, as periodically amended, and all funds received by any person or entity under any such program or activity must be expended for purposes that are consistent with those Best Practices. The State Department of Health shall exercise sole discretion in determining whether components are consistent with the Best Practices for Comprehensive Tobacco Control Programs of the federal Centers for Disease Control and Prevention.

(5) Funding for the different components of the program shall be apportioned between the components based on the recommendations in the Best Practices for Comprehensive Tobacco Control Programs of the federal Centers for Disease Control and Prevention, as periodically amended, or any additional programs as determined by the State Board of Health to provide adequate program development, implementation and evaluation for effective control of the use of tobacco products. While the office shall develop annual budgets based on strategic planning, components of the program shall be funded using the following areas as guidelines for priority:

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(a) School nurses and school programs;

(b) Mass media (counter-marketing);

(c) Cessation programs (including media promotions);

(d) Community programs;

(e) Surveillance and evaluation;

(f) Law enforcement; and

(g) Administration and management; however, not more than five percent (5%) of the total budget may be expended for administration and management purposes.

(6) In funding the components of the program, the State Department of Health may provide funding for health care programs at the University of Mississippi Medical Center that are related to the prevention and cessation of the use of tobacco products and the treatment of illnesses that are related to the use of tobacco products.

(7) No statewide, district, local, county or municipal elected official shall take part as a public official in mass media advertising under the provisions of this chapter.

(8) Statewide health improvement grants.

(a) Beginning July 1, 2009, the State Board of Health, Office of Tobacco Control, shall award competitive grants to convene, coordinate and implement evidence-based strategies targeted at reducing the percentage of Mississippians who are obese or overweight and to reduce the use of tobacco.

(b) Grantee activities shall:

(i) Be based on scientific evidence;

(ii) Be based on community input;

(iii) Address behavior change at the individual, community, and systems levels;

(iv) Occur in community, school, worksite, and health care settings; and

(v) Be focused on policy, systems, and environmental changes that support healthy behaviors.
(c) To receive a grant under this section, grantees must submit proposals to the Office of Tobacco Control. A local match of ten percent (10%) of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, grantees must submit a health improvement plan to the Office of Tobacco Control for approval. The Office of Tobacco Control may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the interventions, and modify or discontinue interventions found to be ineffective.

(f) By January 15, 2011, the Office of Tobacco Control shall recommend whether any funding should be distributed to grantees based on health disparities demonstrated in the populations served.

(g) Grant recipients shall report their activities and their progress toward the outcomes established to the Office of Tobacco Control in a format and at a time specified by the Office of Tobacco Control.

(h) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in paragraph (i). The Office of Tobacco Control shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

(i) Outcomes. The Office of Tobacco Control shall set measurable outcomes to meet the goals specified in subsection (8), and annually review the progress of grant recipients in meeting the outcomes. The Office of Tobacco Control shall measure current
public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

(j) Technical assistance and oversight. The Office of Tobacco Control shall provide content expertise, technical expertise, and training to grant recipients and advice on evidence-based strategies, including those based on populations and types of communities served. The Office of Tobacco Control shall ensure that the statewide health improvement program meets the outcomes established under paragraph (i) by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

(k) Evaluation. Using the outcome measures established in paragraph (i), the Office of Tobacco Control shall conduct a biennial evaluation of the statewide health improvement program funded under this section. Grant recipients shall cooperate with the Office of Tobacco Control in the evaluation and provide the Office of Tobacco Control with the information necessary to conduct the evaluation.

(l) Report. The Office of Tobacco Control shall submit a biennial report to the Legislature on the statewide health improvement program funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the Office of Tobacco Control shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. In the report due on January 15, 2010, the Office of Tobacco Control shall include recommendations on a sustainable funding source for the statewide health improvement program.

(m) Supplantation of existing funds. Grantees must use funds received under this section to develop new programs, expand
current programs that work to reduce the percentage of
Mississippians who are obese or overweight or who use tobacco, or
replace discontinued state or federal funds previously used to
reduce the percentage of Mississippians who are obese or
overweight or who use tobacco. Funds must not be used to supplant
current state or local funding used to reduce the percentage of
Mississippians who are obese or overweight or to reduce tobacco
use.

SECTION 3. Health care homes. (1) Definitions. For
purposes of this section, the following definitions apply:

(a) "Personal clinician" means a licensed physician, a
registered and practicing physician assistant, or a licensed nurse
practitioner.

(b) "State health care program" means the Mississippi
Medicaid program, the State Child Health Plan (S.C.H.I.P.)
established under Section 41-86-3 et seq., the State and School
Employees Health Insurance Plan established under Section 25-15-3
et seq., and any cafeteria health plan administered for the
employees of a county, municipality, community college district,
or any other political subdivision of the State of Mississippi
pursuant to Section 25-15-101 et seq.

(c) "Administering entities" means the Executive
Director of the Division of Medicaid, Office of the Governor, the
State and School Employees Health Insurance Management Board and
the Mississippi Commissioner of Insurance, acting jointly.

(2) Development and implementation of standards.

(a) By July 1, 2009, the Executive Director of the
Division of Medicaid, the State and School Employees Health
Insurance Management Board and the Mississippi Commissioner of
Insurance shall jointly develop and implement standards of
certification for health care homes for state health care
programs. In developing these standards, the three (3)
administering entities shall consider existing standards developed
by national independent accrediting and medical home
organizations. The standards developed by the administering
entities must meet the following criteria:

(i) Emphasize, enhance, and encourage the use of
primary care, and include the use of primary care physicians,
advanced practice nurses, and physician assistants as personal
clinicians;

(ii) Focus on delivering high-quality, efficient,
and effective health care services;

(iii) Encourage patient-centered care, including
active participation by the patient and family or a legal guardian
as appropriate in decision making and care plan development, and
providing care that is appropriate to the patient's race,
ethnicity, and language;

(iv) Provide patients with a consistent, ongoing
contact with a personal clinician or team of clinical
professionals to ensure continuous and appropriate care for the
patient's condition;

(v) Ensure that health care homes develop and
maintain appropriate comprehensive care plans for their patients
with complex or chronic conditions, including an assessment of
health risks and chronic conditions;

(vi) Enable and encourage utilization of a range
of qualified health care professionals, including dedicated care
coordinators, in a manner that enables providers to practice to
the fullest extent of their license;

(vii) Focus initially on patients who have or are
at risk of developing chronic health conditions;

(viii) Incorporate measures of quality, resource
use, cost of care, and patient experience;

(ix) Ensure the use of health information
technology and systematic follow-up, including the use of patient
registries; and
(x) Encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the administering entities shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The administering entities may satisfy this requirement by consulting with the Medical Care Advisory Committee.

(c) For the purposes of developing and implementing these standards, the administering entities may use the administrative rulemaking process provided by law.

(3) Requirements for clinicians certified as health care homes.

(a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. In order to be certified as a health care home, a clinician or clinic must meet the standards set by the administering entities in accordance with this section. Certification as a health care home is voluntary. In order to maintain their status as health care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subsection (5).
(4) Alternative models. Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under development, or preclude the administering entities from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs, are enrolled in managed care long-term care programs, are dually eligible for Medicare and Medicaid, are in the waiting period for Medicare, or who have other primary coverage.

(5) Health care home collaborative. By July 1, 2009, the administering entities shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

(6) Evaluation and continued development.

(a) For continued certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the administering entities. The administering entities shall collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.

(b) The administering entities may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subsection is classified as exempt from the open records law.

(7) Outreach. Beginning July 1, 2009, the administering entities shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

SECTION 4. Health care home reporting requirements. (1) Annual reports on implementation and administration. The
administering entities shall report annually to the Legislature on
the implementation and administration of the health care home
model for state health care program enrollees in the
fee-for-service, managed care, and county-based purchasing sectors
beginning December 15, 2009, and each December 15 thereafter.

(2) Evaluation reports. The administering entities shall
provide to the Legislature comprehensive evaluations of the health
care home model three (3) years and five (5) years after
implementation. The report must include:

(a) The number of state health care program enrollees
in health care homes and the number and characteristics of
enrollees with complex or chronic conditions, identified by
income, race, ethnicity, and language;

(b) The number and geographic distribution of health
care home providers;

(c) The performance and quality of care of health care
homes;

(d) Measures of preventive care;

(e) Health care home payment arrangements, and costs
related to implementation and payment of care coordination fees;

(f) The estimated impact of health care homes on health
disparities; and

(g) Estimated savings from implementation of the health
care home model for the fee-for-service, managed care, and
county-based purchasing sectors.

SECTION 5. Payment restructuring; care coordination
payments. (1) Development. The administering entities shall
develop a payment system that provides per person care
coordination payments to health care homes certified under Section
2 for providing care coordination services and directly managing
on-site or employing care coordinators. The care coordination
payments under this section are in addition to the quality
incentive payments in Section 4. The care coordination payment
system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination. In developing the criteria for care coordination payments, the administering entities shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The administering entities may determine a schedule for phasing in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions. Development of the payment system must be completed by January 1, 2010.

(2) Implementation. The administering entities shall implement care coordination payments as specified under this section by July 1, 2010, or upon federal approval, whichever is later. For enrollees served under the fee-for-service system, the care coordination payment shall be determined by the administering entities in contracts with certified health care homes. For enrollees served by managed care or county-based purchasing plans, the administering entities' contracts with these plans shall require the payment of care coordination fees to certified health care homes.

(3) Cost neutrality. If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the administering entities may make recommendations to the Legislature on reallocating costs within the health care system.

SECTION 6. Payment reform. (1) Quality incentive payments. By July 1, 2010, the administering entities shall implement quality incentive payments for all enrollees in state health care programs consistent with relevant state and federal statute and rule. This section does not limit the ability of the administering entities to establish by contract and monitor, as
part of its quality assurance obligations for state health care programs, outcome and performance measures for nonmedical services and health issues likely to occur in low-income populations or racial or cultural groups disproportionately represented in state health care program enrollment that would likely be underrepresented when using traditional measures that are based on longer-term enrollment.

(2) Payment reform. By January 1, 2011, the administering entities shall use the information and methods developed under this section to establish a payment system that:

(a) Rewards high-quality, low-cost providers;

(b) Creates enrollee incentives to receive care from high-quality, low-cost providers; and

(c) Fosters collaboration among providers to reduce cost shifting from one (1) part of the health continuum to another.

SECTION 7. Workforce shortage study. To address health care workforce shortages, the administering entities, in consultation with the health licensing boards and professional associations, shall study changes necessary in health professional licensure and regulation to ensure full utilization of advanced practice registered nurses, physician assistants, and other licensed health care professionals in the health care home and primary delivery system. The administering entities shall make recommendations to the Legislature by January 15, 2009.

SECTION 8. Free and reduced school lunch program data sharing. (1) Each school participating in the federal school lunch program shall electronically send to the Department of Education the eligibility information on each child who is eligible for the free and reduced lunch program, unless the child’s parent or legal guardian after being notified of the potential disclosure of this information for the limited purpose
stated in subsection (2) elects not to have the information disclosed.

(2) Pursuant to United States Code, Title 42, Section 1758(b)(6)(A), the Department of Education shall enter into an agreement with the Division of Medicaid and the State and School Employees Health Insurance Management Board to share the eligibility information provided by each school in subsection (1) for the limited purpose of identifying children who may be eligible for Medicaid or State Children's Health Insurance Program (S.C.H.I.P.) assistance. The administering entities must ensure that this information remains confidential and shall only be used for this purpose. Any unauthorized disclosure shall be subject to a penalty.

(3) Application and renewal forms. The administering entities shall make state health care program applications and renewals available on the State Department of Education Web site in the most common foreign languages.

(4) Incentive program. Beginning July 1, 2009, the administering entities shall establish an incentive program for organizations and licensed insurance producers that directly identify and assist potential enrollees in filling out and submitting an application. For each applicant who is successfully enrolled in Medicaid assistance, or S.C.H.I.P., the administering entities, within the available appropriation, shall pay the organization or licensed insurance producer a Twenty-five Dollars ($25.00) application assistance bonus. The organization or licensed insurance producer may provide an applicant a gift certificate or other incentive upon enrollment.

(5) School districts.

(a) At the beginning of each school year, a school district shall provide information to each student on the availability of health care coverage through the Mississippi health care programs.
(b) For each child who is determined to be eligible for
the free and reduced school lunch program, the district shall
provide the child's family with information on how to obtain an
application for the Mississippi health care programs and
application assistance.

(c) A district shall also ensure that applications and
information on application assistance are available at early
childhood education sites and public schools located within the
district's jurisdiction.

(d) Each district shall designate an enrollment
specialist to provide application assistance and follow-up
services with families who have indicated an interest in receiving
information or an application for the Mississippi health care
program. A district is eligible for the application assistance
bonus described in subsection (4).

(e) Each school district shall provide on their Web
site a link to information on how to obtain an application and
application assistance.

SECTION 9. Seamless coverage for S.C.H.I.P. eligible
children. A child receiving Medicaid assistance under Section
43-13-115 et seq., who becomes ineligible due to excess income, is
eligible for seamless coverage between Medicaid assistance and
S.C.H.I.P. benefits. The child shall remain automatically
eligible under this section for two (2) additional months and is
deemed automatically eligible for S.C.H.I.P. until renewal.
S.C.H.I.P. coverage begins in accordance with Section 41-86-5 et
seq.

SECTION 10. Section 41-86-3, Mississippi Code of 1972, is
amended as follows:

41-86-3. (1) There is established a statewide Children's
Health Insurance Program under Title XXI of the Social Security
Act to provide child health care assistance to targeted,
uninsured, low-income children to be administered by the Division
of Medicaid in the Office of the Governor. The term "targeted, low-income child" means a child through age eighteen (18) who has been determined eligible for child health assistance and who is a low-income child, or is a child whose family income exceeds the Medicaid applicable income level, but does not exceed three hundred percent (300%) of the federal poverty level, and is not eligible for medical assistance under Title XIX or is not covered under a group health plan.

(2) The Children's Health Insurance Program shall provide the same benefits to children enrolled in the program as are provided to Medicaid recipients under the Mississippi Medicaid Laws, Section 43-13-117.

(3) The Children's Health Insurance Program shall be established subject to the availability of funds specifically appropriated by the Legislature for this purpose and federal matching funds as set forth in Title XXI of the Social Security Act.

(4) In administering the Children's Health Insurance Program, the Division of Medicaid shall have all the authority, duties and responsibilities set forth in Section 43-13-101 et seq.

(5) This section authorizes the Division of Medicaid to submit a temporary plan for children's health insurance to the U.S. Department of Health and Human Services.

(6) From and after the full implementation of the permanent State Child Health Plan authorized under Section 5 of this act, this section shall have no force and effect.

SECTION 11. Section 41-86-5, Mississippi Code of 1972, is amended as follows:

41-86-5. As used in Sections 41-86-5 through 41-86-17, the following definitions shall have the meanings ascribed in this section, unless the context indicates otherwise:

(a) "Act" means the Mississippi Children's Health Care
(b) "Administering agency" means the agency designated by the Mississippi Children's Health Insurance Program Commission to administer the program.

(c) "Board" means the State and Public School Employees Health Insurance Management Board created under Section 25-15-303.

(d) "Child" means an individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance.

(e) "Commission" means the Mississippi Children's Health Insurance Program Commission created by Section 41-86-7.

(f) "Covered benefits" means the types of health care benefits and services provided to eligible recipients under the Children's Health Care Program.

(g) "Division" means the Division of Medicaid in the Office of the Governor.

(h) "Low-income child" means a child whose family income does not exceed three hundred percent (300%) of the poverty level for a family of the size involved.

(i) "Plan" means the State Child Health Plan.

(j) "Program" means the Children's Health Care Program established by Sections 41-86-5 through 41-86-17.

(k) "Recipient" means a person who is eligible for assistance under the program.

(l) "State Child Health Plan" means the permanent plan that sets forth the manner and means by which the State of Mississippi will provide health care assistance to eligible uninsured, low-income children consistent with the provisions of Title XXI of the federal Social Security Act, as amended.

SECTION 12. The following shall be codified as Section 41-86-16, Mississippi Code of 1972:

41-86-16. (1) Sliding fee scale; monthly gross individual or family income.
(a) The administering entities shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the S.C.H.I.P. program. The sliding fee scale must be based on the enrollee’s monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one (1), two (2), or three (3) or more persons. Until June 30, 2010, the sliding fee scale begins with a premium of one and five tenths percent (1.5%) of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 2009, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 2009, to two hundred seventy-five percent (275%) of the federal poverty guidelines for the applicable family size, up to a family size of five (5). The sliding fee scale for a family of five (5) must be used for families of more than five (5). If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above two hundred seventy-five percent (275%) of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one (1), two (2), or three (3) or more enrollees so that if all S.C.H.I.P. cases paid the maximum premium, the total revenue would equal the total cost of S.C.H.I.P. medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent (10%) of the total. The costs of medical coverage for pregnant women and children under age two (2) and the enrollees in...
these groups shall be excluded from the total. The maximum premium for two (2) enrollees shall be twice the maximum premium for one (1), and the maximum premium for three (3) or more enrollees shall be three (3) times the maximum premium for one (1).

(c) Beginning July 1, 2009, S.C.H.I.P. enrollees shall pay premiums according to the premium scale specified in paragraph (d) with the exception that children in families with income at or below one hundred fifty percent (150%) of the federal poverty guidelines shall pay a monthly premium of Four Dollars ($4.00). For purposes of paragraph (d), "minimum" means a monthly premium of Four Dollars ($4.00).

(d) The following premium scale is established for individuals and families with gross family incomes of three hundred percent (300%) of the federal poverty guidelines or less:

<table>
<thead>
<tr>
<th>Federal Poverty Guideline Range</th>
<th>Percent of Average Gross Monthly Income</th>
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<tbody>
<tr>
<td>0-45%</td>
<td>minimum</td>
</tr>
<tr>
<td>46-54%</td>
<td>1.1%</td>
</tr>
<tr>
<td>55-81%</td>
<td>1.6%</td>
</tr>
<tr>
<td>82-109%</td>
<td>2.2%</td>
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<tr>
<td>110-136%</td>
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<td>6.5%</td>
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<tr>
<td>249-274%</td>
<td>7.2%</td>
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<tr>
<td>275-300%</td>
<td>8.0%</td>
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(2) Children may remain enrolled in S.C.H.I.P. if ten percent (10%) of their gross individual or gross family income is less than the annual premium for a policy with a Five Hundred Dollars ($500.00) deductible as determined by the administering entities. Children who are no longer eligible for S.C.H.I.P.
under this section shall be given a twelve-month notice period from the date that ineligibility is determined before disenrollment. The premium for children remaining eligible under this section shall be the maximum premium determined under this section.

(3) Notwithstanding subsections (1) and (2), parents are not eligible for S.C.H.I.P. if gross household income exceeds Fifty-seven Thousand Five Hundred Dollars ($57,500.00) for the twelve-month period of eligibility.

SECTION 13. By January 15, 2010, the Executive Director of the Department of Human Services shall report to the Legislature on ways to improve coordination between state health care programs and social service programs, including, but not limited to, WIC and food stamps. This report must include a review of options for the development of automated systems to identify persons served by social service programs who may be eligible for, but are not enrolled in, a state health care program. The report shall identify to the Legislature statutory changes to state health care and social service programs necessary to improve coordination and automation between state health care programs and social service programs.

SECTION 14. (1) The Mississippi Commissioner of Insurance shall study and report to the Legislature by December 15, 2010, with recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market. The commissioner shall collect necessary actuarial data, employment data, current coverage data, and other needed information. The commissioner shall develop cost estimates for three (3) levels of insurance coverage for long-term care workers:

(a) The coverage provided to state employees;

(b) The coverage provided to Medicaid enrollees; and
(c) The benefits provided under an "average" private market insurance product, but with a deductible limited to One Hundred Dollars ($100.00) per person.

Premium cost sharing, waiting periods for eligibility, definitions of full- and part-time employment, and other parameters under the three (3) options must be identical to those under the state employees health plan.

(3) For purposes of this section, a long-term care worker is a person employed by a nursing facility, an intermediate care facility for persons with developmental disabilities, or a service provider that provides assisted living services.

The commissioner may recommend a different definition of long-term care worker if this definition presents insurmountable implementation issues.

(4) The recommendations must include measures to:

(a) Ensure equitable treatment between employers that currently have different levels of expenditure for employee health insurance costs; and

(b) Enforce the requirement that the rate increase be expended for the intended purpose.


(a) The Mississippi Commissioner of Insurance (commissioner) is authorized to request proposals or to negotiate and to enter into contracts with parties which in the judgment of the commissioner are best qualified to provide service to the health benefit plans available to citizens of the State of Mississippi. The commissioner may negotiate premium rates and coverage. The commissioner shall consider the cost of the plans, conversion options relating to the contracts, service capabilities, character, financial position, and reputation of the carriers, and any other factors which the commissioner deems appropriate. Each benefit contract must be for a uniform term of
at least one (1) year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. A carrier licensed in the State of Mississippi is exempt from the taxes imposed on premiums paid to it by the state.

(b) All self-insured hospital and medical service products must comply with coverage mandates, data reporting, and consumer protection requirements applicable to the licensed carrier administering the product, had the product been insured. Any self-insured products that limit coverage to a network of providers or provide different levels of coverage between network and nonnetwork providers shall comply with licensure and geographic access standards for health maintenance organizations adopted by the Commissioner of Insurance.

(c) Notwithstanding paragraph (b), a self-insured hospital and medical product offered under this section is not required to extend dependent coverage to an eligible employee's unmarried child under the age of twenty-five (25) to the full extent required under this section. Dependent coverage must, at a minimum, extend to an eligible employee's unmarried child who is under the age of nineteen (19) or an unmarried child under the age of twenty-five (25) who is a full-time student. The definition of "full-time student" for purposes of this paragraph includes any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least sixty percent (60%) of what otherwise is considered by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this definition of "full-time student."

(d) Beginning January 1, 2010, the health insurance benefit plans offered in the commissioner's plan under this section must include an option for a health plan that is
compatible with the definition of a high-deductible health plan in
Section 223 of the United States Internal Revenue Code.

SECTION 16. Interoperable electronic health record
requirements. Hospitals and health care providers must meet the
following criteria when implementing an interoperable electronic
health records system within their hospital system or clinical
practice setting:

(a) The electronic health record must be certified by
the Certification Commission for Healthcare Information
Technology, or its successor. This criterion only applies to
hospitals and health care providers whose practice setting is a
practice setting covered by Certification Commission for
Healthcare Information Technology certifications. This criterion
shall be considered met if a hospital or health care provider is
using an electronic health records system that has been certified
within the last three (3) years, even if a more current version of
the system has been certified within the three-year period.

(b) A health care provider who is a prescriber or
dispenser of controlled substances must have an electronic health
record system that meets the requirements of the State Board of
Pharmacy.

SECTION 17. Electronic prescription drug program. (1)
Definitions. For the purposes of this section, the following
terms have the meanings given.

(a) "Dispense" or "dispensing" has the meaning given in
the Pharmacy Practice Act. Dispensing does not include the direct
administering of a controlled substance to a patient by a licensed
health care professional.

(b) "Dispenser" means a person authorized by law to
dispense a controlled substance, pursuant to a valid prescription.

(c) "Electronic media" has the meaning given under Code
of Federal Regulations, Title 45, Part 160.103.
(d) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

(e) "Electronic prescription drug program" means a program that provides for e-prescribing.

(f) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(g) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, Title 45, Part 162.406.

(h) "NCPDP" means the National Council for Prescription Drug Programs, Inc.


(k) "Pharmacy" has the meaning given in the Pharmacy Practice Act.

(l) "Prescriber" means a licensed health care professional who is authorized to prescribe a controlled substance by the State Board of Pharmacy.

(m) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.
(n) "Provider" or "health care provider" has the meaning given in the Pharmacy Practice Act.

(2) Requirements for electronic prescribing.

(a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish and maintain an electronic prescription drug program that complies with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) Nothing in this section requires providers, group purchasers, prescribers, or dispensers to conduct the transactions described in this section. If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

(d) Entities transmitting prescriptions or prescription-related information where the prescriber is required by law to issue a prescription for a patient to a nonprescribing
provider that in turn forwards the prescription to a dispenser are exempt from the requirement to use the NCPDP SCRIPT Standard when transmitting prescriptions or prescription-related information.

(3) Standards for electronic prescribing.

(a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(i) Get message transaction;
(ii) Status response transaction;
(iii) Error response transaction;
(iv) New prescription transaction;
(v) Prescription change request transaction;
(vi) Prescription change response transaction;
(vii) Refill prescription request transaction;
(viii) Refill prescription response transaction;
(ix) Verification transaction;
(x) Password change transaction;
(xi) Cancel prescription request transaction; and
(xii) Cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct
SECTION 18. Definitions. (1) Applicability. For purposes of this section, the terms defined in this section have the meanings given, unless otherwise specified:

(a) "Basket" or "baskets of care" means a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

(b) "Clinically effective" means that the use of a particular health technology or service improves or prevents a decline in patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology or service demonstrates a clinical or outcome advantage over alternative technologies or services. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

(c) "Commissioner" means the Mississippi Commissioner of Insurance unless otherwise specified.

(d) "Cost-effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement or prevent a decline in a patient's health outcome are justified given the comparison to both the economic costs and the improvement or prevention of decline in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the
individual's present or predicted disability, degree of medical
dependency, or quality of life.

(e) "Group purchaser" has the meaning provided in
regulations of the Mississippi Commissioner of Insurance.

(f) "Health plan" means a health plan as defined in
Section 83-9-1 et seq.

(g) "Health plan company" has the meaning provided in
Section 83-9-1 et seq.

(h) "Participating provider" means a provider who has
entered into a service agreement with a health plan company.

(i) "Provider" or "health care provider" means a health
care provider as defined in Section 83-9-1 et seq.

(j) "Service agreement" means an agreement, contract,
or other arrangement between a health plan company and a provider
under which the provider agrees that when health services are
provided for an enrollee, the provider shall not make a direct
charge against the enrollee for those services or parts of
services that are covered by the enrollee's contract, but shall
look to the health plan company for the payment for covered
services, to the extent they are covered.

(k) "State health care program" means the Medicaid
assistance, S.C.H.I.P., the State and School Employees Health
Insurance Plan, and general assistance medical care programs.

(l) "Third-party administrator" means a vendor of
risk-management services or an entity administering a
self-insurance or health insurance plan under Section 83-9-1 et
seq.

(2) Payment restructuring; incentive payments based on
quality of care.

(a) The Commissioner of Insurance shall develop a
standardized set of measures by which to assess the quality of
health care services offered by health care providers, including
health care providers certified as health care homes under this
act. Quality measures must be based on medical evidence and be developed through a process in which providers participate. The measures shall be used for the quality incentive payment system developed in subsection (2) and must:

(i) Include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

(ii) Seek to avoid increasing the administrative burden on health care providers;

(iii) Be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations, including, but not limited to, Mississippi Community Measurement and specialty societies;

(iv) Place a priority on measures of health care outcomes, rather than process measures, wherever possible; and

(v) Incorporate measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner.

(b) The measures shall be reviewed at least annually by the commissioner.

(3) Quality incentive payments.

(a) By July 1, 2009, the commissioner shall develop a system of quality incentive payments under which providers are eligible for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, and improvement over time. The targets must be based upon and consistent with the quality measures established under subsection (1).

(b) To the extent possible, the payment system must adjust for variations in patient population, in order to reduce incentives to health care providers to avoid high-risk patients or populations.
(4) Quality transparency. The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue annual public reports on provider quality beginning July 1, 2010. By January 1, 2010, physician clinics and hospitals shall submit standardized electronic information on the outcomes and processes associated with patient care to the commissioner or the commissioner's designee. In addition to measures of care processes and outcomes, the report may include other measures designated by the commissioner, including, but not limited to, care infrastructure and patient satisfaction. The commissioner shall ensure that any quality data reporting requirements established under this subsection are not duplicative of publicly reported, communitywide quality reporting activities currently under way in Mississippi. Nothing in this subsection is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Mississippi.

(5) Contracting. The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subsections (1) through (4). The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plan companies, consumers, employers or other health care purchasers, and state government. No one (1) stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

(6) Implementation.

(a) By January 1, 2010, health plan companies shall use the standardized quality measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.
(b) By July 1, 2010, the commissioner shall implement this incentive payment system for all participants in the state employee group insurance program.

(7) Payment restructuring; care coordination payments.

(a) By January 1, 2010, health plan companies shall include health care homes in their provider networks and by July 1, 2010, shall pay a care coordination fee for their members who choose to enroll in health care homes certified under this act. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under this act. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes. Health plan companies may reduce or reallocate payments to other providers to ensure that implementation of care coordination payments is cost neutral.

(b) By July 1, 2010, the State and School Employees Health Insurance Management Board shall implement the care coordination payments for participants in the state employee group insurance program. The board may reallocate payments within the health care system in order to ensure that the implementation of this section is cost neutral.

(8) Payment reform to reduce health care costs and improve quality.

(a) Development of tools to improve costs and quality outcomes. The Commissioner of Insurance shall develop a plan to create transparent prices, encourage greater provider innovation and collaboration across points on the health continuum in cost-effective, high-quality care delivery, reduce the administrative burden on providers and health plans associated with submitting and processing claims, and provide comparative information to consumers on variation in health care cost and
quality across providers. The development must be complete by
January 1, 2010.

(b) Calculation of health care costs and quality. The Commissioner of Insurance shall develop a uniform method of
calculating providers' relative cost of care, defined as a measure
of health care spending including resource use and unit prices, and relative quality of care. In developing this method, the
commissioner must address the following issues:

(i) Provider attribution of costs and quality;
(ii) Appropriate adjustment for outlier or catastrophic cases;
(iii) Appropriate risk adjustment to reflect differences in the demographics and health status across provider patient populations, using generally accepted and transparent risk adjustment methodologies;
(iv) Specific types of providers that should be included in the calculation;
(v) Specific types of services that should be included in the calculation;
(vi) Appropriate adjustment for variation in payment rates;
(vii) The appropriate provider level for analysis;
(viii) Payer mix adjustments, including variation across providers in the percentage of revenue received from government programs; and
(ix) Other factors that the commissioner determines are needed to ensure validity and comparability of the analysis.

(9) Provider peer grouping.

(a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. In
developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Mississippi. For purposes of the final establishment of the peer grouping system, the commissioner shall not contract with any private entity, organization, or consortium of entities that has or will have a direct financial interest in the outcome of the system.

(b) Beginning June 1, 2010, the commissioner shall disseminate information to providers on their cost of care, resource use, quality of care, and the results of the grouping developed under this subsection in comparison to an appropriate peer group. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data and submit comments. The provider shall have twenty-one (21) days to review the data for accuracy.

(c) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports.

(d) Beginning September 1, 2010, the commissioner shall, no less than annually, publish information on providers' cost, quality, and the results of the peer grouping process. The results that are published must be on a risk-adjusted basis.

(10) Encounter data.

(a) Beginning July 1, 2009, and every six (6) months thereafter, all health plan companies and third-party administrators shall submit encounter data to a private entity designated by the Commissioner of Insurance. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:
(i) The data must be de-identified data as described under the Code of Federal Regulations, Title 45, Section 164.514;

(ii) The data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home; and

(iii) Except for the identifier described in subparagraph (ii), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under this section.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) for the purpose of carrying out its responsibilities in this section, and must maintain the data that it receives according to the provisions of this section.

(c) Data on providers collected under this subsection are private data on individuals or nonpublic data. Summary data prepared under this subsection may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(11) Pricing data.

(a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit data on their contracted prices with health care providers to a private entity designated by the Commissioner of Insurance for the purposes of performing the analyses required under this subsection. The data shall be submitted in the form and manner specified by the Commissioner of Insurance.
(b) The commissioner or the commissioner's designee shall only use the data submitted under this subsection for the purpose of carrying out its responsibilities under this section.

(c) Data collected under this subsection are nonpublic data as defined in the Mississippi Open Records Law. Summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(12) Contracting. The commissioner may contract with a private entity or consortium of entities to develop the standards. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plan companies, hospitals, consumers, employers or other health care purchasers, and state government. The entity or consortium must ensure that the representatives of stakeholder groups in the aggregate reflect all geographic areas of the state. No one (1) stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

(13) Consumer engagement. The Commissioner of Insurance shall convene a work group to develop strategies for engaging consumers in understanding the importance of health care cost and quality, specifically as it relates to health care outcomes, consumer out-of-pocket costs, and variations in health care cost and quality across providers. The work group shall develop strategies to assist consumers in becoming advocates for higher value health care and a more efficient, effective health care system. The work group shall make recommendations to the commissioner and the Legislature by January 1, 2010, and shall identify specific action steps needed to achieve the recommendations.
(14) Provider innovation to reduce health care costs and improve quality.
   (a) Nothing in this section shall prohibit group purchasers and health care providers, upon mutual agreement, from entering into arrangements that establish package prices for a comprehensive set of services or separately for the cost of care for specific health conditions in addition to the baskets of care established in this section, in order to give providers the flexibility to innovate on ways to reduce health care costs while improving overall quality of care and health outcomes.
   (b) The Commissioner of Insurance may convene working groups of private sector payers and health care providers to discuss and develop new strategies for reforming health care payment systems to promote innovative care delivery that reduces health care costs and improves quality.

(15) Uses of information.
   (a) By January 1, 2011:
      (i) The State and School Employees Health Insurance Plan Management Board shall use the information and methods developed under subsection (3) to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;
      (ii) All political subdivisions that offer health benefits to their employees must offer plans that differentiate providers on their cost and quality performance and create incentives for members to use better-performing providers;
      (iii) All health plan companies shall use the information and methods developed under subsection (3) to develop products that encourage consumers to use high-quality, low-cost providers; and
      (iv) Health plan companies that issue health plans in the individual market or the small employer market must offer at least one (1) health plan that uses the information developed
under subsection (3) to establish financial incentives for
consumers to choose higher-quality, lower-cost providers through
enrollee cost-sharing or selective provider networks.

(b) By January 1, 2011, the board shall report to the
Governor and the Legislature on recommendations to encourage
health plan companies to promote widespread adoption of products
that encourage the use of high-quality, low-cost providers. The
board's recommendations may include tax incentives, public
reporting of health plan performance, regulatory incentives or
changes, and other strategies.

(16) Provider pricing for baskets of care. Establishment of
definitions.

(a) By July 1, 2009, the Commissioner of Insurance
shall establish uniform definitions for baskets of care beginning
with a minimum of seven (7) baskets of care. In selecting health
conditions for which baskets of care should be defined, the
commissioner shall consider coronary artery and heart disease,
diabetes, asthma, and depression. In selecting health conditions,
the commissioner shall also consider the prevalence of the health
conditions, the cost of treating the health conditions, and the
potential for innovations to reduce cost and improve quality.

(b) The commissioner shall convene one or more work
groups to assist in establishing these definitions. Each work
group shall include members appointed by statewide associations
representing relevant health care providers and health plan
companies, and organizations that work to improve health care
quality in Mississippi.

(c) To the extent possible, the baskets of care must
incorporate a patient-directed, decision-making support model.

(d) Beginning January 1, 2010, health care providers
may establish package prices for the baskets of care defined under
subsection (9).
(e) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser.

This paragraph applies only to health care services provided to Mississippi residents or to non-Mississippi residents who obtain health insurance through a Mississippi employer.

This paragraph does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

(f) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner may contract with an organization that works to improve health care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(g) Beginning July 1, 2010, the commissioner or the commissioner's designee shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available.

(h) Coordination. In carrying out the responsibilities of this section, the Commissioner of Insurance shall ensure that the activities and data collection are implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner
shall use existing data sources and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

(i) Legislative oversight. Beginning January 15, 2009, the Commissioner of Insurance shall submit to the Legislature periodic progress reports on the implementation of this act.

SECTION 19. Section 125 plans. (1) Definitions. For purposes of this section, the following terms have the meanings given them:

(a) "Employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on the employed person or persons.

(c) "Section 125 Plan" means a cafeteria or premium-only plan under Section 125 of the Internal Revenue Code that allows employees to pay for health coverage premiums with pretax dollars.

(d) "Small employer" means an employer with two (2) to fifty (50) employees.

(2) Section 125 Plan requirement.

(a) Effective July 1, 2009, all employers with eleven (11) or more current full-time equivalent employees in this state shall establish and maintain a Section 125 Plan to allow their employees to purchase individual market or employer-based health coverage with pretax dollars. Nothing in this section requires employers to offer or purchase group health coverage for their employees. The following employers are exempt from the Section 125 Plan requirement:

(i) Employers that provide self-insurance; or
(ii) Employers that have no employees who are eligible to participate in a Section 125 Plan.

(b) Notwithstanding paragraph (a), an employer may opt out of the requirement to establish a Section 125 Plan by sending a form to the Commissioner of Insurance. The Commissioner of Insurance shall create a check-box form for employers to opt out. The form must contain a check box indicating the employer is choosing to opt out and a check box indicating that the employer certifies they have received education and information on the advantages of Section 125 Plans. The Commissioner of Insurance shall make the form available through their Web site by April 1, 2009.

(3) Employer requirements.

(a) Employers that do not offer a health plan as defined in this section that is group coverage and are required to offer or choose to offer a Section 125 Plan shall:

(i) Allow employees to purchase an individual market health plan for themselves and their dependents;
(ii) Allow employees to choose any insurance producer licensed in accident and health insurance under Title 83 to assist them in purchasing an individual market health plan;
(iii) Upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the health plan; and
(iv) Provide notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered.

(b) Employers shall be held harmless from any and all claims related to the individual market health plans purchased by employees under a Section 125 Plan.

(4) Section 125 Plan employer incentives.

(a) The commissioner shall award grants to eligible small employers that establish Section 125 Plans.
In order to be eligible for a grant, a small employer must:

(i) Not have offered health insurance to employees through a group health insurance plan as defined in Section 83-9-1 et seq. or through a self-insured plan as defined in Section 83-9-1 et seq. in the twelve (12) months prior to applying for grant funding under this section;

(ii) Have established a Section 125 Plan within ninety (90) days prior to applying for grant funding under this section, and must not have offered a Section 125 Plan to employees for at least a nine-month period prior to the establishment of the Section 125 Plan under this section; and

(iii) Certify to the commissioner that the employer has established a Section 125 Plan and meets the requirements of subsection (3).

The amount of the grant awarded to a small employer under this section shall be Three Hundred Fifty Dollars ($350.00).

SECTION 20. Essential benefit set. (1) Work group created. The Commissioner of Insurance shall convene a work group to make recommendations on the design of a health benefit set that provides coverage for a broad range of services and technologies, is based on scientific evidence that the services and technologies are clinically effective and cost-effective, and provides lower enrollee cost sharing for services and technologies that have been determined to be cost-effective. The work group shall include representatives of health care providers, health plans, state agencies, and employers. Members of the work group must have expertise in standards for evidence-based care, benefit design and development, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits. The work group must meet at least once per year and at other times as necessary to make recommendations to the commissioner on
updating the benefit set as necessary to ensure that the benefit set continues to be safe, effective, and scientifically based.

(2) Duties. By October 15, 2009, the work group shall develop and submit to the commissioner an initial essential benefit set and design that includes coverage for a broad range of services, is based on scientific evidence that services are clinically effective and cost-effective, and provides lower enrollee cost sharing for services that have been determined to be cost-effective. The benefit set must include necessary evidence-based health care services, procedures, diagnostic tests, and technologies that are scientifically proven to be both clinically effective and cost-effective. In developing its recommendations, the work group may consult with the University Medical Center to assemble existing scientifically based practice standards.

(3) Report. By January 15, 2010, the commissioner shall report the recommendations of the work group to the chairs of the legislative committees with jurisdiction over health care policy and finance.

SECTION 21. Health care reform review council. (1) Establishment. The Health Care Reform Review Council is established for the purpose of periodically reviewing the progress of implementation of this act.

(2) Members.

(a) The Health Care Reform Review Council shall consist of fourteen (14) members who are appointed as follows:

(i) Two (2) members appointed by the Mississippi Medical Association, at least one (1) of whom must represent rural physicians;

(ii) One (1) member appointed by the Mississippi Nurses Association;
(iii) Two (2) members appointed by the Mississippi Hospital Association, at least one (1) of whom must be a rural hospital administrator;

(iv) One (1) member appointed by the Mississippi Academy of Physician Assistants;

(v) One (1) member appointed by the Mississippi Economic Council;

(vi) One (1) member appointed by the Mississippi Manufacturers Association;

(vii) One (1) member appointed by the AFL-CIO;

(viii) One (1) consumer member appointed by AARP Mississippi; and

(ix) Four (4) members appointed by the Governor.

(b) If a member is no longer able or eligible to participate, a new member shall be appointed by the entity that appointed the outgoing member.

(3) Operations of council.

(a) The Commissioner of Insurance shall convene the first meeting of the council on or before January 15, 2010, following the initial appointment of the members and the advisory council must meet at least quarterly thereafter.

(b) The council members shall receive per diems and expense reimbursement as provided by law for conducting council business.

SECTION 22. Study of uniform claims review process. The Commissioner of Insurance shall establish a work group including representatives of the Mississippi Hospital Association, Mississippi Medical Association, and Mississippi Council of Health Plans to make recommendations on the potential for reducing claims adjudication costs of health care providers and health plan companies by adopting more uniform payment methods, and the potential impact of establishing uniform prices that would replace current prices negotiated individually by providers with separate business.
payers. The work group shall make its recommendations to the commissioner by January 1, 2010, and shall identify specific action steps needed to achieve the recommendations.

SECTION 23. Health care affordability proposal. The Commissioner of Insurance shall develop a health care affordability proposal for eligible individuals and employees with access to employer-subsidized health coverage and with gross family incomes of three hundred percent (300%) of the federal poverty guidelines or less. The commissioner must evaluate and report on direct payments to individuals, tax credits, including refundable tax credits, tax deductions and a combination of direct payments, tax credits, and tax deductions as mechanisms for providing affordable health coverage to individuals and families. The proposal must be designed so that qualified individuals and families have access to affordable coverage. For purposes of this section, coverage is "affordable" if the sum of premiums, deductibles, and other out-of-pocket costs paid by an individual or family for health coverage does not exceed the applicable percentage of the individual's or family's gross monthly income set forth in Mississippi income tax law. The commissioner shall submit a report and recommendations to the Legislature by January 15, 2010.

SECTION 24. This act shall take effect and be in force from and after July 1, 2009.