

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:

74 **SECTION 1.** (1) The Office of the Governor, Division of
75 Medicaid, shall enter into negotiations with the Centers for
76 Medicare and Medicaid Services (CMS) to obtain a waiver for
77 applicable provisions of the Medicaid laws and regulations under
78 Section 1115 of the federal Social Security Act to create a plan
79 to allow Medicaid coverage in Mississippi for individuals
80 described in this act, which contains the following provisions:
81 (a) Coverage group. Individuals eligible for coverage
82 under this section shall be persons who are not less than nineteen
83 (19) years of age but less than sixty-five (65) years of age, who
84 currently reside in households that have an income of not more
85 than one hundred thirty-eight percent (138%) of the federal



86 poverty level, and to the extent approved by CMS in the Section
87 1115 waiver, who are:

88 (i) Employed for at least one hundred (100) hours
89 per month in a position for which health insurance is not paid for
90 by the employer;

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

93 (iii) Enrolled full-time in a workforce training
94 program;

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

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

102 (vi) A person who is physically, mentally or
103 intellectually unable to meet the requirements of subparagraphs
104 (i) through (iv) of this paragraph (a) as documented by a medical
105 professional; or

106 (vii) The primary caregiver for a disabled child,
107 spouse or parent, provided that such disabled person qualifies for
108 Medicaid coverage in accordance with the federal Social Security
109 Act.



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

124 The division shall provide qualified providers with such
125 forms as are necessary for an individual in the coverage group to
126 make application for Medicaid and information on how to assist
127 such individuals in completing and filing such forms. The
128 division shall make those application forms and the application
129 process itself as simple as possible. In addition to the efforts
130 of the division, the Department of Health shall administer a
131 public awareness program regarding the coverage and eligibility
132 offered in accordance with this act. Such program shall promote
133 public awareness of the coverage offered in accordance with this
134 act to ensure that all eligible citizens of the State of



135 Mississippi are aware of and have the opportunity to apply for
136 eligibility.

137 (c) Delivery systems.

138 (i) All individuals in the coverage group who
139 currently reside in households that have an income of less than
140 one hundred percent (100%) of the federal poverty level shall be
141 enrolled in and their services shall be provided by the managed
142 care organizations (MCOs), coordinated care organizations (CCOs),
143 provider-sponsored health plans (PSHPs) and other such
144 organizations paid for services to the Medicaid population on a
145 capitated basis by the division as described in Section
146 43-13-117(H).

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



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

162 (d) Benefit packages. Individuals enrolled under this
163 act who are not less than nineteen (19) years of age but less than
164 sixty five (65) years of age shall be provided essential health
165 services as determined by the division, which shall, at a minimum,
166 include ambulatory patient services, emergency services,
167 hospitalization, prescription drugs, rehabilitative services,
168 laboratory services, primary care services, preventive and
169 wellness services and chronic disease management.

170 (e) Funding of the plan.

171 (i) The Section 1115 waiver described in this
172 section shall describe the funding for this act, which shall be a
173 combination of state matching funds and federal matching funds in
174 the proportions specified under the federal Affordable Care Act at
175 the time of the effective date of this act.

176 (ii) The state matching funds shall include
177 contributions from MCOs, CCOs, PSHPs and other such organizations
178 paid for services to the Medicaid population on a capitated basis
179 by the division as described in Section 43-13-117(H) in the form
180 of an assessment as provided in Section 2 of this act and all
181 other revenue sources as provided in this act. The state matching
182 funds shall also include contributions from hospitals that are
183 generated through an assessment on hospitals as described in



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

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

190 (iv) If the funds derived from subparagraphs (ii)
191 through (iii) of this paragraph and Sections 27-15-103 (4) and
192 27-15-109 (4) are lower than the amount needed to account for the
193 state's matching funds, funds derived from the three percent (3%)
194 taxes levied in Sections 27-15-103 and 27-15-109 shall be diverted
195 to account for the state's matching funds. Notwithstanding any
196 provision of this paragraph (e), state matching funds for the
197 purposes of this act may also be appropriated by the Legislature
198 from any other sources.

199 (f) Timing. Within one hundred twenty (120) days of
200 the effective date of this act, the division shall apply for a
201 waiver of the applicable provisions of the Medicaid laws and
202 regulations under Section 1115 of the federal Social Security Act
203 to create a plan to allow Medicaid coverage in Mississippi in
204 accordance with this act, which shall include a work requirement
205 that requires beneficiaries to be employed for at least one
206 hundred (100) hours per month or for such beneficiary to be
207 otherwise eligible within paragraph (a) of this subsection. The
208 division shall provide a copy of such application to the Governor,



209 Lieutenant Governor, Speaker of the House of Representatives, and
210 the Chairmen of the Senate and House Medicaid Committees on the
211 same day that the division officially applies to CMS for such
212 waiver.

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

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

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

222 **SECTION 2.** (1) Notwithstanding any other provision of law,
223 upon each managed care organization, coordinated care
224 organization, provider sponsored health plan or other organization
225 paid for services to the Medicaid population on a capitated basis
226 by the Division of Medicaid as described in Section 43-13-117(H),
227 there is levied an assessment of three percent (3%) on the total
228 paid capitation. All assessments under this section shall be
229 assessed and collected by the division on the 15th of each month
230 and shall be deposited into the Medicaid Beneficiaries Coverage
231 Special Fund created by subsection (2) of this section. Any
232 amount generated by the assessment that is in excess of the amount
233 needed to cover the state matching funds may be used to enhance



234 provider reimbursement for those services that are most utilized
235 by the coverage group as determined by the division. This section
236 shall be effective in the first month that a capitated payment is
237 provided to a managed care organization, coordinated care
238 organization, provider sponsored health plan or other organization
239 paid for services to the Medicaid population on a capitated basis
240 by the division as described in Section 43-13-117(H) for coverage
241 of individuals eligible under Section 1 of this act and Section
242 43-13-115. The Division of Medicaid is directed to apply for any
243 applicable federal waiver to accomplish the purposes of this
244 section.

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

250 (a) The assessment provided in subsection (1) of this
251 section;

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

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

254 and

255 (d) Any amounts provided from CMS as the federal
256 matching fund proportion for medical services provided to the
257 coverage group.



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

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

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

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

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

271 (i) Are in the coverage group provided in Section
272 1(a) of this act and who currently reside in households that have
273 an income of at least one hundred percent (100%) of the federal
274 poverty level but not more than one hundred thirty-eight percent
275 (138%) of the federal poverty level; and

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

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



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

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

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

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

294 (3) The division shall pay the state's matching fund
295 proportion that is needed to cover the premiums and cost-sharing
296 of any qualified health plan provided to an eligible beneficiary.

297 (4) If a state-based exchange is implemented after the
298 effective date of this act, then all eligible beneficiaries shall
299 be transitioned to qualified health plans offered on the
300 state-based exchange.

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

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



305 (a) On such date that the Centers for Medicare and
306 Medicaid Services (CMS) reject the assessments provided for in
307 this act;

308 (b) On such date that the Centers for Medicare and
309 Medicaid Services (CMS) withdraws approval of, cancels or
310 constructively terminates the work requirement waiver that was
311 previously issued to the division as a condition of the
312 requirements of this act;

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

316 (d) On such date that a court of competent jurisdiction
317 nullifies the assessments provided for in this act; or

318 (e) On such date that the federal matching fund
319 proportion for medical services provided to the coverage group
320 ever falls below ninety percent (90%), or as close to that date as
321 required in order for the division to comply with any federal
322 notice and due process requirements.

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



329 Section 5. (1) If the Centers for Medicare and Medicaid
330 Services (CMS) does not approve the division's work requirement
331 waiver request as provided in Section 1 of this act, the division
332 shall submit to CMS a waiver request to implement all of the
333 provisions of this act, including the work requirements in
334 Section 1 of this act, each year after CMS's initial rejection of
335 the division's work requirement waiver request not later than
336 September 1 of each year.

337 (2) If there is any indication that work requirements as a
338 condition of participation in the Medicaid program may be
339 authorized by CMS earlier than the date for submitting a waiver
340 request as required in subsection (1) of this section, then the
341 division shall enter into negotiations with CMS as soon as
342 possible to implement all of the provisions of Section 1 of this
343 act, including the work requirements in Section 1 of this act.
344 Within thirty (30) days of entering into negotiations with CMS
345 pursuant to this section, the division shall notify, in writing,
346 the Governor, the Lieutenant Governor, the Speaker of the House of
347 Representatives, and the Chairmen of the Senate and House Medicaid
348 Committees of these negotiations.

349 (3) The division shall begin enrolling individuals in the
350 coverage group described in Section 1 of this act within thirty
351 (30) days of the effective date of CMS's approval of the waiver
352 under this section, including the work requirements in Section 1
353 of this act.



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

356 43-13-115. Recipients of Medicaid shall be the following
357 persons only:

358 (1) Those who are qualified for public assistance
359 grants under provisions of Title IV-A and E of the federal Social
360 Security Act, as amended, including those statutorily deemed to be
361 IV-A and low income families and children under Section 1931 of
362 the federal Social Security Act. For the purposes of this
363 paragraph (1) and paragraphs (8), (17) and (18) of this section,
364 any reference to Title IV-A or to Part A of Title IV of the
365 federal Social Security Act, as amended, or the state plan under
366 Title IV-A or Part A of Title IV, shall be considered as a
367 reference to Title IV-A of the federal Social Security Act, as
368 amended, and the state plan under Title IV-A, including the income
369 and resource standards and methodologies under Title IV-A and the
370 state plan, as they existed on July 16, 1996. The Department of
371 Human Services shall determine Medicaid eligibility for children
372 receiving public assistance grants under Title IV-E. The division
373 shall determine eligibility for low income families under Section
374 1931 of the federal Social Security Act and shall redetermine
375 eligibility for those continuing under Title IV-A grants.

376 (2) Those qualified for Supplemental Security Income
377 (SSI) benefits under Title XVI of the federal Social Security Act,
378 as amended, and those who are deemed SSI eligible as contained in



379 federal statute. The eligibility of individuals covered in this
380 paragraph shall be determined by the Social Security
381 Administration and certified to the Division of Medicaid.

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

387 (4) [Deleted]

388 (5) A child born on or after October 1, 1984, to a
389 woman eligible for and receiving Medicaid under the state plan on
390 the date of the child's birth shall be deemed to have applied for
391 Medicaid and to have been found eligible for Medicaid under the
392 plan on the date of that birth, and will remain eligible for
393 Medicaid for a period of one (1) year so long as the child is a
394 member of the woman's household and the woman remains eligible for
395 Medicaid or would be eligible for Medicaid if pregnant. The
396 eligibility of individuals covered in this paragraph shall be
397 determined by the Division of Medicaid.

398 (6) Children certified by the State Department of Human
399 Services to the Division of Medicaid of whom the state and county
400 departments of human services have custody and financial
401 responsibility, and children who are in adoptions subsidized in
402 full or part by the Department of Human Services, including
403 special needs children in non-Title IV-E adoption assistance, who



404 are approvable under Title XIX of the Medicaid program. The
405 eligibility of the children covered under this paragraph shall be
406 determined by the State Department of Human Services.

407 (7) Persons certified by the Division of Medicaid who
408 are patients in a medical facility (nursing home, hospital,
409 tuberculosis sanatorium or institution for treatment of mental
410 diseases), and who, except for the fact that they are patients in
411 that medical facility, would qualify for grants under Title IV,
412 Supplementary Security Income (SSI) benefits under Title XVI or
413 state supplements, and those aged, blind and disabled persons who
414 would not be eligible for Supplemental Security Income (SSI)
415 benefits under Title XVI or state supplements if they were not
416 institutionalized in a medical facility but whose income is below
417 the maximum standard set by the Division of Medicaid, which
418 standard shall not exceed that prescribed by federal regulation.

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

425 (9) Individuals who are:

426 (a) Children born after September 30, 1983, who
427 have not attained the age of nineteen (19), with family income



428 that does not exceed one hundred percent (100%) of the nonfarm
429 official poverty level;

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

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

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

440 (10) Certain disabled children age eighteen (18) or
441 under who are living at home, who would be eligible, if in a
442 medical institution, for SSI or a state supplemental payment under
443 Title XVI of the federal Social Security Act, as amended, and
444 therefore for Medicaid under the plan, and for whom the state has
445 made a determination as required under Section 1902(e)(3)(b) of
446 the federal Social Security Act, as amended. The eligibility of
447 individuals under this paragraph shall be determined by the
448 Division of Medicaid.

449 (11) Until the end of the day on December 31, 2005,
450 individuals who are sixty-five (65) years of age or older or are
451 disabled as determined under Section 1614(a)(3) of the federal
452 Social Security Act, as amended, and whose income does not exceed



453 one hundred thirty-five percent (135%) of the nonfarm official
454 poverty level as defined by the Office of Management and Budget
455 and revised annually, and whose resources do not exceed those
456 established by the Division of Medicaid. The eligibility of
457 individuals covered under this paragraph shall be determined by
458 the Division of Medicaid. After December 31, 2005, only those
459 individuals covered under the 1115(c) Healthier Mississippi waiver
460 will be covered under this category.

461 Any individual who applied for Medicaid during the period
462 from July 1, 2004, through March 31, 2005, who otherwise would
463 have been eligible for coverage under this paragraph (11) if it
464 had been in effect at the time the individual submitted his or her
465 application and is still eligible for coverage under this
466 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
467 coverage under this paragraph (11) from March 31, 2005, through
468 December 31, 2005. The division shall give priority in processing
469 the applications for those individuals to determine their
470 eligibility under this paragraph (11).

471 (12) Individuals who are qualified Medicare
472 beneficiaries (QMB) entitled to Part A Medicare as defined under
473 Section 301, Public Law 100-360, known as the Medicare
474 Catastrophic Coverage Act of 1988, and whose income does not
475 exceed one hundred percent (100%) of the nonfarm official poverty
476 level as defined by the Office of Management and Budget and
477 revised annually.



478 The eligibility of individuals covered under this paragraph
479 shall be determined by the Division of Medicaid, and those
480 individuals determined eligible shall receive Medicare
481 cost-sharing expenses only as more fully defined by the Medicare
482 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
483 1997.

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

491 (b) Individuals entitled to Part A of Medicare,
492 with income above one hundred twenty percent (120%), but less than
493 one hundred thirty-five percent (135%) of the federal poverty
494 level, and not otherwise eligible for Medicaid. Eligibility for
495 Medicaid benefits is limited to full payment of Medicare Part B
496 premiums. The number of eligible individuals is limited by the
497 availability of the federal capped allocation at one hundred
498 percent (100%) of federal matching funds, as more fully defined in
499 the Balanced Budget Act of 1997.

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

502 (14) [Deleted]



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

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

518 (17) In accordance with the terms of the federal
519 Personal Responsibility and Work Opportunity Reconciliation Act of
520 1996 (Public Law 104-193), persons who become ineligible for
521 assistance under Title IV-A of the federal Social Security Act, as
522 amended, because of increased income from or hours of employment
523 of the caretaker relative or because of the expiration of the
524 applicable earned income disregards, who were eligible for
525 Medicaid for at least three (3) of the six (6) months preceding
526 the month in which the ineligibility begins, shall be eligible for
527 Medicaid for up to twelve (12) months. The eligibility of the



528 individuals covered under this paragraph shall be determined by
529 the division.

530 (18) Persons who become ineligible for assistance under
531 Title IV-A of the federal Social Security Act, as amended, as a
532 result, in whole or in part, of the collection or increased
533 collection of child or spousal support under Title IV-D of the
534 federal Social Security Act, as amended, who were eligible for
535 Medicaid for at least three (3) of the six (6) months immediately
536 preceding the month in which the ineligibility begins, shall be
537 eligible for Medicaid for an additional four (4) months beginning
538 with the month in which the ineligibility begins. The eligibility
539 of the individuals covered under this paragraph shall be
540 determined by the division.

541 (19) Disabled workers, whose incomes are above the
542 Medicaid eligibility limits, but below two hundred fifty percent
543 (250%) of the federal poverty level, shall be allowed to purchase
544 Medicaid coverage on a sliding fee scale developed by the Division
545 of Medicaid.

546 (20) Medicaid eligible children under age eighteen (18)
547 shall remain eligible for Medicaid benefits until the end of a
548 period of twelve (12) months following an eligibility
549 determination, or until such time that the individual exceeds age
550 eighteen (18).

551 (21) Women of childbearing age whose family income does
552 not exceed one hundred eighty-five percent (185%) of the federal



553 poverty level. The eligibility of individuals covered under this
554 paragraph (21) shall be determined by the Division of Medicaid,
555 and those individuals determined eligible shall only receive
556 family planning services covered under Section 43-13-117(13) and
557 not any other services covered under Medicaid. However, any
558 individual eligible under this paragraph (21) who is also eligible
559 under any other provision of this section shall receive the
560 benefits to which he or she is entitled under that other
561 provision, in addition to family planning services covered under
562 Section 43-13-117(13).

563 The Division of Medicaid shall apply to the United States
564 Secretary of Health and Human Services for a federal waiver of the
565 applicable provisions of Title XIX of the federal Social Security
566 Act, as amended, and any other applicable provisions of federal
567 law as necessary to allow for the implementation of this paragraph
568 (21). The provisions of this paragraph (21) shall be implemented
569 from and after the date that the Division of Medicaid receives the
570 federal waiver.

571 (22) Persons who are workers with a potentially severe
572 disability, as determined by the division, shall be allowed to
573 purchase Medicaid coverage. The term "worker with a potentially
574 severe disability" means a person who is at least sixteen (16)
575 years of age but under sixty-five (65) years of age, who has a
576 physical or mental impairment that is reasonably expected to cause
577 the person to become blind or disabled as defined under Section



578 1614(a) of the federal Social Security Act, as amended, if the
579 person does not receive items and services provided under
580 Medicaid.

581 The eligibility of persons under this paragraph (22) shall be
582 conducted as a demonstration project that is consistent with
583 Section 204 of the Ticket to Work and Work Incentives Improvement
584 Act of 1999, Public Law 106-170, for a certain number of persons
585 as specified by the division. The eligibility of individuals
586 covered under this paragraph (22) shall be determined by the
587 Division of Medicaid.

588 (23) Children certified by the Mississippi Department
589 of Human Services for whom the state and county departments of
590 human services have custody and financial responsibility who are
591 in foster care on their eighteenth birthday as reported by the
592 Mississippi Department of Human Services shall be certified
593 Medicaid eligible by the Division of Medicaid until their
594 twenty-first birthday.

595 (24) Individuals who have not attained age sixty-five
596 (65), are not otherwise covered by creditable coverage as defined
597 in the Public Health Services Act, and have been screened for
598 breast and cervical cancer under the Centers for Disease Control
599 and Prevention Breast and Cervical Cancer Early Detection Program
600 established under Title XV of the Public Health Service Act in
601 accordance with the requirements of that act and who need
602 treatment for breast or cervical cancer. Eligibility of



603 individuals under this paragraph (24) shall be determined by the
604 Division of Medicaid.

605 (25) The division shall apply to the Centers for
606 Medicare and Medicaid Services (CMS) for any necessary waivers to
607 provide services to individuals who are sixty-five (65) years of
608 age or older or are disabled as determined under Section
609 1614(a)(3) of the federal Social Security Act, as amended, and
610 whose income does not exceed one hundred thirty-five percent
611 (135%) of the nonfarm official poverty level as defined by the
612 Office of Management and Budget and revised annually, and whose
613 resources do not exceed those established by the Division of
614 Medicaid, and who are not otherwise covered by Medicare. Nothing
615 contained in this paragraph (25) shall entitle an individual to
616 benefits. The eligibility of individuals covered under this
617 paragraph shall be determined by the Division of Medicaid.

618 (26) The division shall apply to the Centers for
619 Medicare and Medicaid Services (CMS) for any necessary waivers to
620 provide services to individuals who are sixty-five (65) years of
621 age or older or are disabled as determined under Section
622 1614(a)(3) of the federal Social Security Act, as amended, who are
623 end stage renal disease patients on dialysis, cancer patients on
624 chemotherapy or organ transplant recipients on antirejection
625 drugs, whose income does not exceed one hundred thirty-five
626 percent (135%) of the nonfarm official poverty level as defined by
627 the Office of Management and Budget and revised annually, and



628 whose resources do not exceed those established by the division.
629 Nothing contained in this paragraph (26) shall entitle an
630 individual to benefits. The eligibility of individuals covered
631 under this paragraph shall be determined by the Division of
632 Medicaid.

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

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

644 (29) Individuals described in Section (1)(a) of this
645 act. The division shall apply for a waiver of the applicable
646 provisions of the Medicaid laws and regulations under Section 1115
647 of the federal Social Security Act to create a plan to allow
648 Medicaid coverage in Mississippi in accordance with this act,
649 including a work requirement that requires beneficiaries to be
650 employed for at least one hundred (100) hours per month or for
651 such beneficiary to be otherwise eligible within Section (1)(a) of
652 this act. The division shall begin enrolling eligible individuals



653 into the coverage group established in this section within thirty
654 (30) days of the effective date of CMS approving the division's
655 waiver under this section. This subsection shall be subject to
656 Section 4 of this act.

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

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

662 27-15-103. (1) Except as otherwise provided in Section
663 83-61-11, in addition to the license tax now or hereafter provided
664 by law, which tax shall be paid when the company enters or is
665 admitted to do business in this state, there is hereby levied and
666 imposed upon all foreign insurance companies and associations,
667 including life insurance companies and associations, health,
668 accident and industrial insurance companies and associations, fire
669 and casualty insurance companies and associations, and all other
670 foreign insurance companies and associations of every kind and
671 description, an additional annual license or privilege tax of
672 three percent (3%) of the gross amount of premium receipts
673 received from, and on insurance policies and contracts written in,
674 or covering risks located in this state, except for premiums
675 received on policies issued to fund a deferred compensation plan
676 qualified under Section 457 of the Federal Tax Code for federal
677 tax exemption. In determining said amount of premiums, there



678 shall be deducted therefrom premiums received for reinsurance from
679 companies authorized to do business in this state, cash dividends
680 paid under policy contracts in this state, and premiums returned
681 to policyholders and cancellations on accounts of policies not
682 taken, and, in the case of mutual insurance companies (including
683 interinsurance and reciprocal exchanges, but not including mutual
684 life, accident, health or industrial insurance companies) any
685 refund made or credited to the policyholder other than for losses.
686 The term "premium" as used herein shall also include policy fees,
687 membership fees, and all other fees collected by the companies.
688 No credit or deduction from gross premium receipts shall be
689 allowed for any commission, fee or compensation paid to any agent,
690 solicitor or representative. Provided, however, that any foreign
691 insurance carrier selected to furnish service to the State of
692 Mississippi under the State Employees Life and Health Insurance
693 Plan shall not be required to pay the annual license or privilege
694 tax on the premiums collected for coverage under the said plan.

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



702 (3) The taxes herein levied and imposed for the calendar
703 year 1982 and all calendar years thereafter shall be reduced by
704 the net amount of income tax paid to this state for the preceding
705 calendar year, provided, in no event may the credit be taken more
706 than once. The credit herein authorized shall, in no event, be
707 greater than the premium tax due under this section; it being the
708 purpose and intent of this paragraph that whichever of the annual
709 insurance premium tax or the income tax is greater in amount shall
710 be paid.

711 (4) In addition to the license tax now or hereafter provided
712 by law and the tax provided in subsection (1) of this section,
713 which tax shall be paid when the company enters or is admitted to
714 do business in this state, there is hereby levied and imposed upon
715 all foreign health insurance companies and associations that offer
716 qualified health plans to eligible beneficiaries in accordance
717 with Section 3 of this act, an additional annual license or
718 privilege tax of one percent (1%) of the gross amount of premium
719 receipts received from, and on insurance policies and contracts
720 written for, the qualified health plans provided to eligible
721 beneficiaries by such foreign health insurance companies and
722 associations in accordance with Section 3 of this act. For
723 purposes of this subsection, "premium" means a charge that must be
724 paid as a condition of enrolling in health care coverage. This
725 subsection (4) shall be subject to Section 4 of this act.



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

728 27-15-109. (1) Except as otherwise provided in Section
729 83-61-11, there is hereby levied and imposed upon each domestic
730 company doing business in this state an annual tax of three
731 percent (3%) of the gross amount of premiums collected by such
732 domestic company on insurance policies and contracts written in,
733 or covering risks located in this state, except for premiums
734 received on policies issued to fund a retirement, thrift or
735 deferred compensation plan qualified under Section 401, Section
736 403 or Section 457 of the Federal Tax Code for federal tax
737 exemption. Provided, however, that a domestic insurance company
738 against which is levied additional premium tax under retaliatory
739 laws of other states in which it does business, as a result of the
740 tax increase provided by Sections 27-15-103 through 27-15-117, may
741 deduct the total of such additional retaliatory tax from the state
742 income tax due by it to the State of Mississippi. The insurance
743 carriers selected to furnish service to the State of Mississippi,
744 under the State Employees Life and Health Insurance Plan, shall
745 not be required to pay the premium tax levied against insurance
746 companies under this section on the premiums collected for
747 coverage under the state employees plan.

748 (2) Except as expressly provided by subsection (1) of this
749 section, all of the provisions of Sections 27-15-103 through
750 27-15-117 shall be applicable to such domestic insurance



751 companies. However, the statement filed with the State Tax
752 Commission by domestic insurance companies as provided in Section
753 27-15-107 shall include therein a sworn statement of all
754 additional retaliatory premium taxes paid by them to other states
755 as a result of the increase in premium taxes imposed by Sections
756 27-15-103 through 27-15-117, itemized by states to which paid.

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

764 (4) In addition to the license tax now or hereafter provided
765 by law and the tax provided in subsection (1) of this section,
766 there is hereby levied and imposed upon each domestic health
767 insurance company doing business in this state that offers
768 qualified health plans to eligible beneficiaries in accordance
769 with Section 3 of this act, an additional annual license or
770 privilege tax of one percent (1%) of the gross amount of premium
771 receipts received from, and on insurance policies and contracts
772 written for, the qualified health plans provided to eligible
773 beneficiaries by such domestic health insurance companies and
774 associations in accordance with Section 3 of this act. For
775 purposes of this subsection, "premium" means a charge that must be



776 paid as a condition of enrolling in health care coverage. This
777 subsection (4) shall be subject to Section 4 of this act.

778 **SECTION 8.** This act shall take effect and be in force from
779 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 PROVIDE THAT IF
50 CMS REJECTS THE DIVISION'S WORK REQUIREMENT WAIVER REQUEST, THE
51 DIVISION SHALL SUBMIT TO CMS A WAIVER REQUEST TO IMPLEMENT ALL OF
52 THE PROVISIONS OF THIS ACT, INCLUDING THE WORK REQUIREMENTS, EACH
53 YEAR AFTER CMS'S INITIAL REJECTION OF THE WORK REQUIREMENT WAIVER
54 REQUEST NOT LATER THAN SEPTEMBER 1 OF EACH YEAR; TO PROVIDE THAT
55 IF THERE IS ANY INDICATION THAT WORK REQUIREMENTS AS A CONDITION
56 OF PARTICIPATION IN THE MEDICAID PROGRAM MAY BE AUTHORIZED BY CMS
57 EARLIER THAN THE REQUIRED DATE FOR SUBMITTING A WAIVER REQUEST,
58 THEN THE DIVISION SHALL ENTER INTO NEGOTIATIONS WITH CMS AS SOON
59 AS POSSIBLE TO IMPLEMENT ALL OF THE PROVISIONS OF THIS ACT,
60 INCLUDING THE WORK REQUIREMENTS; TO PROVIDE THAT THE DIVISION
61 SHALL BEGIN ENROLLING INDIVIDUALS IN THE COVERAGE GROUP WITHIN 30
62 DAYS OF THE EFFECTIVE DATE OF CMS'S APPROVAL OF THE WAIVER,
63 INCLUDING THE WORK REQUIREMENTS; TO AMEND SECTION 43-13-115,
64 MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PROVISIONS OF THE ACT;
65 TO AMEND SECTIONS 27-15-103 AND 27-15-109, MISSISSIPPI CODE OF
66 1972, TO PROVIDE AN ADDITIONAL ANNUAL LICENSE OR PRIVILEGE TAX OF
67 1% OF THE GROSS AMOUNT OF PREMIUM RECEIPTS RECEIVED FROM, AND ON
68 INSURANCE POLICIES AND CONTRACTS WRITTEN FOR, THE QUALIFIED HEALTH
69 PLANS PROVIDED TO ELIGIBLE BENEFICIARIES BY FOREIGN AND DOMESTIC
70 HEALTH INSURANCE COMPANIES AND ASSOCIATIONS DOING BUSINESS IN THIS
71 STATE THAT OFFER QUALIFIED HEALTH PLANS TO ELIGIBLE BENEFICIARIES
72 IN ACCORDANCE WITH THIS ACT; AND FOR RELATED PURPOSES.

CONFEREES FOR THE HOUSE

CONFEREES FOR THE SENATE

X (SIGNED)
McGee

X (SIGNED)
Blackwell

X (SIGNED)
Creekmore IV

X (SIGNED)
Boyd

X (SIGNED)
Hood

X (SIGNED)
Wiggins

