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:

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Delivery systems.

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

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

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

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

(e) Funding of the plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) "Eligible individuals" means individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) [Deleted]

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

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

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

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

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

(9) Individuals who are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) [Deleted]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AN ACT TO REQUIRE THE DIVISION OF MEDICAID TO ENTER INTO NEGOTIATIONS WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) TO OBTAIN A WAIVER FOR APPLICABLE PROVISIONS OF THE MEDICAID LAWS AND REGULATIONS UNDER SECTION 1115 OF THE FEDERAL SOCIAL SECURITY ACT TO CREATE A PLAN TO ALLOW MEDICAID COVERAGE IN MISSISSIPPI FOR INDIVIDUALS WITHIN A CERTAIN COVERAGE GROUP; TO PROVIDE THAT THE COVERAGE GROUP SHALL INCLUDE INDIVIDUALS WHO ARE 19 THROUGH 64 YEARS OF AGE WHOSE INCOME IS NOT MORE THAN 138% OF THE FEDERAL POVERTY LEVEL AND ARE EMPLOYED AT LEAST 100 HOURS PER MONTH IN A POSITION FOR WHICH HEALTH INSURANCE IS NOT PAID FOR BY THE EMPLOYER, ARE ENROLLED AS A FULL-TIME STUDENT OR IN WORKFORCE TRAINING, OR ARE OTHERWISE ACTING AS A PRIMARY CAREGIVER FOR A DISABLED CHILD, SPOUSE, OR PARENT; TO PROVIDE THAT ANY INDIVIDUAL OTHERWISE ELIGIBLE FOR COVERAGE UNDER THE ACT WHO HAS HEALTH INSURANCE COVERAGE AND VOLUNTARILY DISENROLLS SUCH COVERAGE SHALL NOT BE ELIGIBLE FOR COVERAGE UNTIL 12 MONTHS AFTER THE ENDING DATE OF THAT COVERAGE; TO PROHIBIT COVERAGE FOR ANY INDIVIDUAL WHO IS NOT A U.S. CITIZEN; TO REQUIRE THE DIVISION TO VERIFY ELIGIBILITY OF EACH BENEFICIARY NO LESS THAN ON AN ANNUAL BASIS; TO PROVIDE THAT ALL INDIVIDUALS IN THE COVERAGE GROUP WHO CURRENTLY RESIDE IN HOUSEHOLDS THAT HAVE AN INCOME OF LESS THAN 100% OF THE FEDERAL POVERTY LEVEL SHALL BE ENROLLED IN AND THEIR SERVICES SHALL BE PROVIDED BY THE MANAGED CARE ORGANIZATIONS (MCOS), COORDINATED CARE ORGANIZATIONS (CCOS), PROVIDER SPONSORED HEALTH PLANS (PSHPS) AND OTHER SUCH ORGANIZATIONS PAID FOR SERVICES TO THE MEDICAID POPULATION ON A CAPITATED BASIS BY THE DIVISION; TO PROVIDE THAT ALL INDIVIDUALS IN THE COVERAGE GROUP WHO CURRENTLY RESIDE IN HOUSEHOLDS THAT HAVE AN INCOME OF AT LEAST 100% OF THE FEDERAL POVERTY LEVEL BUT NOT MORE THAN 138% OF THE FEDERAL POVERTY LEVEL SHALL BE ENROLLED IN AND THEIR SERVICES SHALL BE PROVIDED BY A QUALIFIED HEALTH PLAN OFFERED BY AN INSURER ON THE EXCHANGE; TO PROVIDE CERTAIN EXCEPTIONS; TO PROVIDE THAT INDIVIDUALS ENROLLED UNDER THIS ACT SHALL BE PROVIDED ESSENTIAL HEALTH SERVICES AS DETERMINED BY THE DIVISION, WHICH SHALL, AT A MINIMUM, INCLUDE AMBULATORY PATIENT SERVICES, EMERGENCY SERVICES, HOSPITALIZATION, PRESCRIPTION DRUGS, REHABILITATIVE SERVICES, LABORATORY SERVICES,

PRIMARY CARE SERVICES AND PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT; TO PROVIDE FOR THE FUNDING OF THE PLAN; TO PROVIDE FOR THE LEVY OF AN ASSESSMENT UPON EACH MANAGED CARE ORGANIZATION, COORDINATED CARE ORGANIZATION, PROVIDER SPONSORED HEALTH PLAN OR OTHER ORGANIZATION PAID FOR SERVICES ON A CAPITATED BASIS BY THE DIVISION, IN THE AMOUNT OF 3% ON THE TOTAL PAID CAPITATION; TO CREATE IN THE STATE TREASURY A SPECIAL FUND TO BE KNOWN AS THE "MEDICAID BENEFICIARIES COVERAGE SPECIAL FUND," FOR THE PURPOSE OF PROVIDING THE STATE'S SHARE OF FUNDING THE PLAN PROVIDED IN THIS ACT; TO REQUIRE THE DIVISION TO APPLY FOR A WAIVER OF THE APPLICABLE PROVISIONS OF THE MEDICAID LAWS WITHIN 120 DAYS OF THE EFFECTIVE DATE OF THE ACT; TO PROVIDE CERTAIN CONDITIONS BY WHICH THE ACT MAY BE REPEALED; TO PROVIDE THAT IF CMS REJECTS THE DIVISION'S WORK REQUIREMENT WAIVER REQUEST, THE DIVISION SHALL SUBMIT TO CMS A WAIVER REQUEST TO IMPLEMENT ALL OF THE PROVISIONS OF THIS ACT, INCLUDING THE WORK REQUIREMENTS, EACH YEAR AFTER CMS'S INITIAL REJECTION OF THE WORK REQUIREMENT WAIVER REQUEST NOT LATER THAN SEPTEMBER 1 OF EACH YEAR; TO PROVIDE THAT IF THERE IS ANY INDICATION THAT WORK REQUIREMENTS AS A CONDITION OF PARTICIPATION IN THE MEDICAID PROGRAM MAY BE AUTHORIZED BY CMS EARLIER THAN THE REQUIRED DATE FOR SUBMITTING A WAIVER REQUEST, THEN THE DIVISION SHALL ENTER INTO NEGOTIATIONS WITH CMS AS SOON AS POSSIBLE TO IMPLEMENT ALL OF THE PROVISIONS OF THIS ACT, INCLUDING THE WORK REQUIREMENTS; TO PROVIDE THAT THE DIVISION SHALL BEGIN ENROLLING INDIVIDUALS IN THE COVERAGE GROUP WITHIN 30 DAYS OF THE EFFECTIVE DATE OF CMS'S APPROVAL OF THE WAIVER, INCLUDING THE WORK REQUIREMENTS; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PROVISIONS OF THE ACT; TO AMEND SECTIONS 27-15-103 AND 27-15-109, MISSISSIPPI CODE OF 1972, TO PROVIDE AN ADDITIONAL ANNUAL LICENSE OR PRIVILEGE TAX OF 1% OF THE GROSS AMOUNT OF PREMIUM RECEIPTS RECEIVED FROM, AND ON INSURANCE POLICIES AND CONTRACTS WRITTEN FOR, THE QUALIFIED HEALTH PLANS PROVIDED TO ELIGIBLE BENEFICIARIES BY FOREIGN AND DOMESTIC HEALTH INSURANCE COMPANIES AND ASSOCIATIONS DOING BUSINESS IN THIS STATE THAT OFFER QUALIFIED HEALTH PLANS TO ELIGIBLE BENEFICIARIES 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