



DOUGLAS A. DUCEY
GOVERNOR

STATE OF ARIZONA
OFFICE OF THE GOVERNOR

EXECUTIVE OFFICE

January 11, 2017

The Honorable Kevin McCarthy
House Majority Leader
H-107, US Capitol Building
Washington DC, 20515

Dear Leader McCarthy,

Thank you for inviting Arizona to provide input on the repeal and replacement of the Affordable Care Act (ACA).

I have long been a critic of the ACA. When it was first passed, the American people were told they would "find more choices, more competition, and in many cases, lower prices." Unfortunately, these promises have proven false.

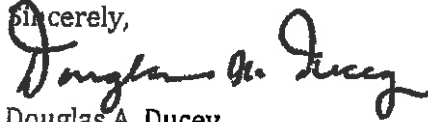
It should come as no surprise that Arizona has been referred to as "ground zero" for the damage inflicted by the ACA. In 2017, most Arizonans shopping for coverage on the federal marketplace in Arizona will have a single choice for coverage and will see an average premium increase of 49 percent, and some people will see increases of over 100%. Additionally, insurers, seeking to protect themselves from further losses, have engaged one of the few options left open to them: narrowing their networks, thereby limiting the ability of consumers to visit the doctor of their choice no matter how sick they may be.

But even as we point out the very real flaws of the ACA, it is important to note that there were flaws in the system we had before. We have all heard the stories of individuals who were unable to find coverage due to a pre-existing condition. These individuals need access to health insurance, and, for them, the thought of repeal and returning to a time when they could not buy coverage at all is very scary. This is why any discussion of repeal, must also include discussion of what replace will look like. I have been clear: I don't want to see any Arizonans have the rug pulled out from under them.

The Honorable Kevin McCarthy
January 11, 2017
Page 2

Please find attached a thorough response to your questions from my Senior Policy Advisor and the Director of Arizona's Medicaid Program. I am extremely grateful for the opportunity to weigh-in on this discussion, and I am eager to provide you with any information and counsel as you move forward.

Sincerely,

A handwritten signature in black ink that reads "Douglas A. Ducey". The signature is written in a cursive style with a large, prominent initial "D".

Douglas A. Ducey
Governor



DOUGLAS A. DUCEY
GOVERNOR

STATE OF ARIZONA
OFFICE OF THE GOVERNOR

EXECUTIVE OFFICE

January 13, 2017

The Honorable Kevin McCarthy
House Majority Leader
H-107, US Capitol Building
Washington, DC 20515

Dear Leader McCarthy,

We would like to thank you for taking the time to reach out to the states for information and input regarding the potential repeal and replacement of the Affordable Care Act (ACA). It is vital that states have a seat at the table in this process as we have seen the consequences of Obamacare up close and can provide insight on that, but we also have an interest in ensuring that our citizens have access to coverage under the replacement plan.

Below, we will address each of your questions individually. Additionally, we are available for any follow-up discussion or to provide any additional information you may request.

1.) What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choice and lower premiums?

Congress should begin by repealing the ACA taxes including the Health Insurance Tax, Medical Device Tax, and the Cadillac Tax. No one should be under the illusion that the Health Insurance Tax is truly paid by the insurance companies. Rather it is passed along to the consumers as part of the premium, thus directly increasing the healthcare costs for individuals. In Arizona alone, this tax directly affected hundreds of thousands of small businesses and roughly a million workers. Moreover, this tax is passed along to state Medicaid programs which operate through managed care. The result being that more efficient Medicaid programs, including Arizona's AHCCCS program which is funded with money from state taxpayers, are paying millions of dollars to subsidize Obamacare while less efficient states who use a fee for service program are not subject to the tax.

This is unfairly shifting additional costs of Obamacare to the taxpayers of a subset of states including Arizona.

Secondly, since 2010, the federal government has usurped control over health insurance. Prior to the passage of the ACA, the vast majority of insurance regulations, with the exception of ERISA plans, was handled by the states. Inflexible, one-size-fits-all federal rules have significantly contributed to increased health insurance costs for individuals and businesses. Congress should return the bulk of insurance regulation over the individual, small-group, and fully insured large-group markets to the states.

Specifically, under the ACA, the Essential Health Benefits mandate spells out what benefits must be covered. Repealing the Essential Health Benefits mandate of the ACA will allow consumers to select a plan with benefits that best fit their personal needs. This is consistent with the principle that individuals, not government, should be able to determine what type of coverage is best for them. Congress should also eliminate the federal age-banding requirements. Allowing states to relax the age-band will encourage younger and healthier people to enter into the market and improve the risk pool. Again, prior to the ACA, both insurance benefit mandates and age-banding were matters for the states and should be returned to the states.

Additionally, Congress should be sure that the replacement plan allows for alternative and new coverage models to develop. Such a plan should provide consideration for healthcare sharing ministries (including allowing for new ones to develop by eliminating the arbitrary date of December 31, 1999 included in the ACA) as well as direct primary care plans that can be coupled with catastrophic insurance.

Congress should also recognize that scope of practice for various types of medical professions including advanced practice nurses, pharmacists, and others varies widely from state to state. Some federal programs fail to recognize these qualified professionals by denying them participation in federal programs even when they are providing safe and effective care pursuant to state scope of practice acts. The result being that federal programs prohibit patients, including in medically underserved areas, from receiving care from qualified professionals even if it means that the patient must instead travel or wait for care. Having all federal programs recognize state scope of practice acts, is a safe and cost-effective approach to improve access to health services.

2.) What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?

Obamacare has created great instability in the Arizona insurance markets. In 2013, prior to the full implementation of the ACA and the opening of the exchanges, Arizona had a thriving and competitive insurance market with over two dozen companies selling plans in the individual market. President Obama promised consumers that they would “find more choices, more competition, and in many cases, lower prices.” Unfortunately, none of those promises have materialized. Instead, this year, Arizonans shopping for coverage on the exchange will have a choice of a single insurer in all but one of our counties. Those same consumers will also see huge increases in their premiums, some in excess of a 100% increase.

Congress must avoid inflicting further damage to the fragile insurance market. As such, Congress must allow sufficient time during the transition from the ACA to the new replacement plan, with the understanding that insurance companies need time to develop new plans and have these new plans reviewed as required by law by each state’s Department of Insurance. This cannot happen overnight, and is likely to require two to three years after passage of the replace plan. To ensure that the market functions in the interim and that thousands of people do not lose existing coverage when new plans are not yet available, Congress should maintain the current subsidies during the transition. Failing to follow through on these federal promises would cause people to lose their plans, prices to increase, and more insurance companies exiting the fragile individual market. Moreover, continuing the subsidies during the transition will ensure that the rug is not pulled out from under people who are currently receiving coverage.

As you know, at the end of 2014, there was an outcry across the country as hundreds of thousands of Americans lost their existing coverage because it did not comply with the burdensome requirements of Obamacare. The outcry was so great that the Obama administration partially capitulated and allowed states to permit the renewal of these plans which became known as transitional plans or grand-mothered plans for a limited time. Dozens of states, including Arizona, made the decision to protect the citizens who had existing plans. During the interim, Congress must also allow states the ability to continue to extend transitional plans so people do not lose existing coverage.

Additionally, repeal of the EHB and national age-banding discussed in response to question one should help to lower costs and increase options. Stabilizing costs will help keep more people in the individual, small-group, and large-group markets. If costs are not

stabilized, more healthy people will continue to leave the insurance market, worsening the pool and increasing the price.

Congress should ensure that insurance plans and employers have wide latitude to develop incentives for plan members to meet health goals such as lowered cholesterol, weight loss, attaining a healthy BMI, smoking cessation, etc. Incentives must be allowed to include premium reductions. Plans should be able to make any incentives contingent on attaining a certain benchmark, not merely participation or attempt.

Finally, Congress must ensure that their replacement plan does not increase hospital uncompensated care. The simple reason for this is that if hospital uncompensated care increases, hospitals will shift those costs to those covered by private insurance, thereby increasing the cost of care across all markets - individual, small-group, and large-group. The problem of uncompensated care could be even more problematic in rural areas where hospitals are unable to shift costs and could be at risk of being forced to close if they face substantial increases in uncompensated care. The federal government has historically recognized this problem and provided supplemental payments to compensate hospitals as it is federal law that requires hospitals to provide coverage without regard to a person's ability to pay.

3.) What are the key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program?

If Congress pursues a new financing structure that caps federal participation in Medicaid going forward through a block grant or per capital limit, then this policy change will result in the single largest transfer of risk ever from the federal government to the states. Statutory changes must accompany this financing change providing significantly more freedom and flexibility.

It is important to note that Arizona experiences some unique challenges associated with such changes in Medicaid financing. Arizona offers fewer optional benefits than most states, has low rates of institutional spending and extensive use of home- and community-based services, operates a mature managed care delivery system, has providers that perform well, and makes few special payments funded with non-state funding. Arizona has operated a more effective and efficient program based on a number of metrics. However, the financing changes being potentially envisioned by Congress may ultimately reward higher cost less efficient states at the expense of states like Arizona that operate a more cost effective program. As the debate around replacement

moves forward, this critical equity issue is very important and must be addressed by policymakers.

As a principle, any formula developed should not be solely based on the current spending of a state. To do so would be to permanently lock in substantial and imbalanced funding variations. Under either a block grant or per capita cap, Congress should strongly consider a base level with limited adjustments that is largely aligned with national averages. This would ensure that states are neither punished for being efficient nor rewarded for being inefficient.

Inflation is another issue that must be adequately addressed. In other block grant programs such as Temporary Assistance For Needy Families (TANF), the block grant is not adjusted annually for inflation. Such a situation would be extremely problematic in Medicaid. It is well known that medical costs increase every year, often at a higher rate than general inflation. As such, any block grant or per capita formula should be tied to medical CPI.

Any new financing structure must be flexible enough to adjust in times of economic downturns. While Governor Ducey's economic policies are improving the state's economic outlook, Arizona has historically been particularly vulnerable during economic recessions and has had an overall lower per capita income to support programs and risk.

Medicaid is a unique federal-state partnership. States contribute a significant portion of the financing and serve as the operational arm. States are equity partners in Medicaid. For all these reasons, and many others, it is important that states be at the table for the important and very complex policy discussions. While we articulate below the main reasons states need extensive flexibility in the administration of the Medicaid program, undoing 50 years of program structure and financing is complex and the impacts cannot be comprehensively summarized in this communication. Therefore, Arizona requests ongoing state involvement in the underlying details of a replacement strategy. The significant impact to states and the ongoing assumption of program risk mean we must be at the table to help formulate these much-needed solutions.

As a state who did enact the Medicaid expansion under a former governor, Governor Ducey is now faced with the fiscal reality associated with the potentially significant loss of federal funding as contemplated under many of the repeal and replace scenarios. To manage through funding reductions of that magnitude, states need to be active participants in shaping the new requirements, and states will need maximum flexibility.

That said, these reforms cannot create uncertainty in funding for states and organizations which are required to have balanced budgets that must be in place in

advance of the fiscal year. Any replacement plan cannot look like the Sustainable Growth Rate program under Medicare that required repeated Congressional action (often retroactively) to fund. It is critical that a replacement program be enacted with the repeal. That replacement program needs to be manageable and provide certainty for states, citizens and providers. It is also vital that if significant new risk is assumed by states through financing changes then considerable additional flexibility will need to be established. Below are some examples that should be considered by policymakers.

Eligibility –

- States should be provided with the latitude to place enrollment caps or enrollment freezes on various eligibility categories. States should also be given considerable latitude around the frequency of the eligibility re-determination which is currently mandated at one year. Another consideration should be an option for states to limit or eliminate Transitional Medical Assistance. States should also be able to include as a condition of eligibility that able-bodied adults are working, looking for work, or training for work.

Benefits –

- Non-Emergency Medical Transportation (NEMT): Congress needs to provide more statutory flexibility around NEMT so that it is not a mandated service for all Medicaid members. At a minimum, it should be optional for non-disabled adults.
- Essential Health Benefits: Congress needs to eliminate the structure of Essential Health Benefits as established by the ACA.
- Pharmacy: The single fastest growing trend for states is in the area of pharmacy expenses. This is also an area where states have very little leverage in establishing rates. If states are going to take on the risk of managing a Medicaid program that is capped, one of the most important changes that needs to occur is that Congress not require states to offer every FDA approved drug. States should only have to offer a drug within the class.
- Comparability and Statewide requirements: Medicaid is also a program that has been traditionally built on comparability (the same benefits for all populations) and state-wideness (availability in all geographic areas). This principle has also stifled the ability for Medicaid to try pilot programs or experiment, as well as to target benefits to populations most in need of them. This statutory framework should be re-structured to allow for flexibility.
- Prohibited benefits: In addition to having fewer mandated benefits, states should have fewer prohibited expenditures. For example, Arizona effectively used in-lieu authority for payments for individuals in Institutions for Mental Disease. The recent

CMS regulations eliminated this authority. States should be allowed to design and determine appropriate service settings.

Cost Sharing –

- The existing statutory and regulatory structure makes imposing personal responsibility on the Medicaid population next to impossible. Congress should simply pick the percent of income that states could assess for each eligibility category at each income level. Beyond that, states should have the flexibility to leverage a variety of mechanisms whether it be premiums, copays, deductibles or other tools to impose cost sharing requirements. In addition, certain administrative requirements regarding the administration of cost sharing are overly burdensome (e.g., non-emergency use of the ED).

Payments –

- **Cost-based Reimbursement Requirements for Federally Qualified Health Centers (FQHCs):** While FQHCs serve as an important part of the delivery system in Arizona, the reimbursement methodology and statutory structure around this provider type is antiquated and unsustainable. Congress should eliminate the requirement that FQHCs receive a cost-based reimbursement structure. Cost-based reimbursement does not align incentives and greatly limits the ability of states to drive value-based purchasing into the delivery system for FQHC related services. Since 2009, the required reimbursement rates for FQHCs in Arizona have risen by 50% as a result of the misaligned incentives inherent in cost-based reimbursement. FQHCs also need to be tied statutorily to the Medicaid benefit package for professional services and not Medicare.
- **Access:** In addition, there is an increasingly prescriptive federal framework surrounding network adequacy and access to care (which are predominantly driven by payment levels). It needs to be recognized that if the financing for the Medicaid program is restructured, states may have to employ more narrow networks while still assuring access to needed services.

Administration –

- Broadly, states should be given extensive flexibility around program administration if Congress makes significant financing model changes. Regulatory restrictions for the Medicaid program are numerous and govern all aspects of the program. Maximum flexibility is critical to allow states to best oversee the program. This flexibility should include more minor program items such as the frequency of eligibility redeterminations, supplemental payments and permissible sources of state matching

funds, as well as more broadly the process for the approval documents of the State Plan and Waivers. Congress must create a statutory path to permanence for successful 1115 waiver programs. Arizona has demonstrated tremendous success in operating mandatory managed care under an 1115 waiver for the past 34 years. However, every five years we continue to have to extensively justify to the federal government why we should be allowed to continue the program that has served as a model for managed care nationally. This process is incredibly burdensome and involves several staff members working on the renewal for nearly 18 months. This process also requires considerable federal resources. In addition, the State plan approval process and capitation rate review process should be greatly streamlined to reduce the burden on states. In addition to the extensive State Plan and Waiver requirements, the Obama administration has promulgated a number of rule packages impacting Medicaid over the past few years, extensively increasing CMS regulation and oversight. These burdens include new requirements on states around managed care, home and community-based services, healthcare access, and mental health parity, just to name a few. These rules should be revisited or repealed to lessen the regulatory burden on states. A final suggestion would be that states be allowed to align eligibility criteria for SNAP and Medicaid. The fact that these programs exist with completely different eligibility requirements (not income level) is ineffective and incredibly inefficient.

Dual eligible members (enrolled in both Medicare and Medicaid) --

- There are approximately 10 million dual eligible members nationally. Historically, service delivery for this complex population has been very fragmented because they have been placed in two different delivery systems (Medicare and Medicaid) that have not done a good job coordinating care. Arizona has been a national leader in serving dual eligible members. Arizona has required our managed care organizations to become Medicare Dual Special Needs Plans so that members can receive both Medicaid and Medicare services from the same plan and we have the highest rate of aligned members in the country. Recently, a third party evaluation (of Minnesota) concluded that aligned members in the same plan for Medicaid and Medicare experienced significantly reduced hospital admissions and readmissions and increased use of primary care services. Congress must continue to work with states on how to better serve the dual eligible population, which will require flexibility and coordination with Medicare, which historically has been challenging and limited. At a minimum, Congress should start by mandating that CMS restore seamless conversion for duals into Medicare Dual Special Needs plans if this is a strategy states and plans are interested in pursuing.

American Indian/Alaska Natives -

- Arizona has a large American Indian population that is funded primarily through federal funding. However, it is important to recognize the complex delivery system for these members. American Indian members who are enrolled in Medicaid can receive services through Indian Health Services (IHS) and tribal providers, but may also receive services through any registered Medicaid provider. Thus, changes to overall Medicaid financing or the requirements of the program (e.g. benefits) will impact service delivery to these members, even if the 100% federal funding for the population is preserved. These complexities will need to be appropriately accounted for as part of future financing proposals.

4.) What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for millions of Americans who receive health coverage through their jobs?

The most important thing that Congress can do to preserve employer-sponsored healthcare is to maintain the associated tax deduction available to employers. Should this be limited or eliminated, many employers may opt to no longer provide insurance for their employees. Additionally, Congress should maintain ERISA, which allows businesses that operate in multiple states to operate under a single set of rules rather than different rules in each state.

One simple step that Congress can take would be to allow Americans the ability to use funds in their FLEX spending accounts to purchase over-the-counter medications without a doctor's prescription. This was permitted prior to the passage of Obamacare and was used by millions of Americans to save on the purchase of allergy medications, cold medication, nicotine gum and patches, and many more. Congress should also consider increasing the amount of funds in an FSA that may be rolled over each year.

Consideration should also be given to increasing the limit on funds for older adults who often have higher medical expenses as well as increasing the limit based on the number of people in the home.

While it is important to ensure that those who get their insurance through their employer do not lose their coverage, it is also important to protect those who are self-employed or otherwise do not have access to an employer-sponsored plan. These individuals deserve the same tax benefit that employers have when they purchase their plans on the individual market. Congress should pass legislation allowing individuals to deduct premium expenses to the same extent that businesses can.

Individuals should also have the ability to shop from the widest array of plans possible which ensures more competition in the market. This means ensuring that insurance products can be sold across state lines.

5.) What key long-term reforms would improve affordability for patients?

Congress should give strong consideration to increasing price transparency within the healthcare market. Many have said that the healthcare market is dysfunctional. One step that could put it on the path to a healthy free market would be increased consumer access to prices, at least in regards to non-emergency services. For any market to be successful, potential consumers need to know the price, and in every other market sector, prices of goods and services are readily available. While some people have suggested that such a move would not make a difference in the healthcare arena, they fail to note that in health care areas not covered by insurance where prices are posted, that market has acted like any other. Prices trend down and competition abounds. You need to look no further than the market for Lasik eye surgery or cosmetic surgery. Both of these were expensive when they were first introduced and then trended down. For example, LASIK now costs less than half of what it did 15 years ago. Supply, demand, and consumer price sensitivity brought down the cost of a healthcare service. Likewise, the cost of cosmetic surgery has grown not only at a lower rate than medical CPI, it has grown at a lower rate than the general CPI. We need to see more of this in healthcare.

Many consumers are now opting for plans with high deductibles or healthcare savings accounts (HSAs). As such, these patients are paying more either out of pocket or out of a personal health savings account. By having prices available, these individuals can make a truly informed choice and potentially save money as well.

Competition lowers prices, and so we should encourage more of it in the healthcare sector. One means to foster competition is to lift the ban imposed by the ACA on new physician-owned hospitals. Some physician owned hospitals including the Surgery Center of Oklahoma and Hoag Orthopedic Institute have adopted novel approaches and publish all of their prices, many of which are below the Medicare reimbursement rate. The care at physician owned hospitals is high quality as well. Although physician-owned hospitals represent a small share of the market, in 2015 seven of the top 10 hospitals which received quality bonuses under the Hospital Value-Based Purchasing program were physician owned hospitals. Many physicians owned hospitals are more charitable than their traditional hospital counterparts. In fact, a CMS study showed physician owned hospitals spent a high percent of their total revenue on community benefits as compared to other hospitals.

6.) Does your state currently have or plan to enact authority to utilize a Section 1332 Waiver for state innovation? If allowed, would your state utilize a coordinated waiver application process for both 1115 and 1332 for benefit year 2017?

Arizona has no plans to apply for a Section 1332 waiver for benefit year 2017. The current rules are much too restrictive and seem to be designed largely for a state that wishes to move to a single-payer system. While Congress seemed to intend to provide states with greater flexibility in designing a 1332 waiver, similar to the flexibility seen in an 1115 waiver, the rules that were promulgated by the Department were much more restrictive. We encourage Congress and the new administration to significantly modify the rules to allow more flexibility. If that happens, Arizona will consider applying.

7.) As part of returning more choice, control, and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?

Risk pools have traditionally been successful in covering a limited number of people at a very high cost. We would certainly consider it, but any decision would depend on the financing structure.

8.) What timing issues, such as budget deadlines, your legislative calendar, and any consumer notifications and insurance rate form and review requirements should we consider when making changes?

Legislative Calendar – The Arizona Legislature meets every year. Session begins the second week of January. Session typically concludes sometime between April and early June.

Budget Deadlines – Agencies submit their budget requests to the Governor's office by September 1 of each year. The Governor is required to release his executive budget recommendations by the second week of January. The Legislature is then required to adopt the annual budget by June 30th. The state fiscal year runs from July 1 – June 30.

Annual Insurance Regulatory Timeline for 2017

5/3/2017 – deadline for insurers to file their 2018 policies and rates with ADOI.

6/25/2017 – deadline for insurers to notify the ADOI Director of intent to exit the AZ Individual or Small Group market. (ARS Section 20-1380(D), 45 CFR 147.106 and 148.122).

7/1/2017 – deadline for insurers to notify customers of market exit. (ARS Section 20-1380(D), 45 CFR 147.106 and 148.122).

8/1/2017 – deadline for ADOI to post initial rate filings.

8/21/2017 – deadline for insurers to file with ADOI any final changes to marketplace policy forms and rates, as well as begin implementing final changes to their 2018 operations and systems for claims, premium collections, enrollment, provider networks and education, etc. (2018 Letter to Issuers in the Federally-facilitated Marketplaces). This federal deadline could be eliminated or amended with federal changes.

9/15/2017 – deadline for ADOI to review/approve all marketplace policy forms and rates and communicate results to CMS.

9/20/2017 – deadline for insurers to send notices to ADOI and customers regarding any specific 2017 plans that are being discontinued (as opposed to a market exit).

10/6/2017 – deadline for insurers to finalize all 2018 non-QHP form/rate filings.

11/1/2017 – Open Enrollment and deadline for ADOI to post all final rate increases.

9.) Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would repeal have on these state law changes?

Yes, the state has adopted portions of the ACA at three state agencies – AHCCCS, the Department of Insurance, and the Department of Health Services.

AHCCCS

- **MAGI:** The state has implemented the new eligibility requirements from 2010 into our Medicaid program and rebuilt our eligibility system to accommodate those changes. At this point it would be very expensive to move away from the Modified Adjusted Gross Income (MAGI) structure for eligibility. Creation of a new system

would cost tens of millions of dollars and could run into the hundreds of millions of dollars.

- **Eligibility:** Arizona has also expanded Medicaid eligibility. While that decision was made by a previous administration, the expansion categories now covers over 400,000 Arizonans. Arizona has a state law passed by the voters that requires Medicaid coverage to all individuals with incomes up to 100% of the FPL, if funding is available for that coverage. This adds complexity to any policy discussion surrounding coverage. In addition, the instability surrounding financing changes could undermine the managed care delivery system that is a cornerstone of Arizona's successful managed care Medicaid program. Given the complexity around Medicaid policy decisions, it is important both for the business and healthcare community that works with the state in our public private partnership, and the two million individuals covered by Medicaid in Arizona that Congress enact a replacement strategy at the same time that the Affordable Care Act is repealed and provide sufficient transition for the replacement to become operational.
- **Drug Rebates:** Arizona has implemented the prescription drug rebate program for Managed Care Organizations. This change provided equity for states that leverage private sector companies to manage the delivery of care. Managed care has become the preferred delivery system for Medicaid and for good reason. Managed care leverages competition and private sector principles in a manner that delivers results. Expanding the drug rebate to states that rely on managed care resolved an inequity that favored un-managed fee-for-service delivery systems, and this authority should be continued.
- **Children's Health Insurance:** Arizona recently decided to re-open its CHIP program, which had been frozen to new enrollment for the past several years. Significant changes in the CHIP financing structure could force Arizona to re-examine this issue again.

Arizona Department of Insurance

- Effective 10/3/2012, ADOI amended its Individual health insurance rate review standards by regulation in order to be deemed to have "effective rate review." [ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE, Arizona Administrative Code R20-6-2301 through R20-6-2305]. If the ACA were repealed, this regulation would remain in effect unless revised or repealed. The "effective rate review status" would be rendered moot as well as certain elements of the regulations that reference federal law. DOI would need to do an in-depth legal review to clarify specific aspects of the regulations that are not tied to the federal review standards and may continue to stand alone to provide rate review standards for the Department.

- Effective 9/13/2013, HB2550, Ch 215 added Arizona Revised Statutes §20-238 to establish health insurance “rating” areas. However, the bill stated that if the ACA is repealed, this provision is conditionally repealed. If repealed, Arizona law will revert and insurers could then set rates based on self-designated “rating areas” as they did prior to the ACA.
- HB2550, Ch 215 (effective 9/13/2013) also amended ARS §20-2537 to modify certain timeframes related to Healthcare Appeals. These modified timeframes are repealed if the ACA is repealed and the timeframes would revert to the prior timeframes.
- HB2332, Ch 116 amended ARS §§ 20-1057.02, 20-1076, 20-2304, and 20-2323 (effective July 3, 2015) to remove certain health insurance consumer disclosure forms which were replaced by the federal Summaries of Benefits and Coverages (SBC). If the SBC requirement is eliminated, Arizona may need to consider legislation to provide Arizona consumers with benefit disclosures.
- There are some timing and content distinctions between federal and Arizona renewal and non-renewal notice requirements. If the ACA were repealed, we would revert to existing AZ law on these notices.

Arizona Department of Health Services

- While the ACA provided new funds in the area of public health, it also brought many pre-existing programs under its authority. We want to ensure that these important public health funds managed in Arizona by the Department of Health Services, many of which pre-date the ACA, are still available. Examples include:
 - **MIEC Home Visiting grants: New program authorized by ACA**
 - **Personal Responsibility Education Program: New program authorized by ACA**
 - **Abstinence Education: Existed prior to ACA**
 - **Prevention and Public Health Fund (PPHF)-funded programs: Most parts that were combined to make the PPHF existed before the ACA**
 - **"1305" Grant for Obesity, Diabetes, Heart Disease, School Health (partly PPHF): New grant that combined pre-existing chronic disease funds, but was incorporated into the PPHF after the ACA. However, these funds existed prior to the ACA**

The Honorable Kevin McCarthy

January 13, 2017

Page 15

- Well Woman Breast Cancer Prevention (partly PPHF; this year's award did not have any PPHF funds, but previous years' have): **Existed prior to ACA**
- Public Health Block Grant: **Existed prior to ACA (fully funded by PPHF, but established by an earlier legislative act, in 1981)**
- Smokers' Quitline Capacity
- BRFSS (partly PPHF): **Existed prior to ACA (~1998)**
- Childhood Lead Poisoning Prevention: **Existed prior to ACA**
- Immunizations and Vaccines for Children (partly PPHF): **Existed prior to ACA**
- ELC Epidemiology and Lab Capacity Program (partly PPHF): **Existed prior to ACA (~ early 2000's)**
- 4 vTrvkS/Immunization Information System capacity building grants: **Began with ACA and is now PPHF**
- State Loan Repayment Program (received under same CFDA before ACA was passed, but CFDA now indicates funding is authorized by ACA): **Existed prior to ACA**

We thank you again for considering input from the states as this important discussion regarding repealing and replacing the ACA begins. We sincerely hope that you will ensure states continue to have a seat at the table throughout the process.

Please feel free to contact us with any follow up questions you may have.

Sincerely,



Tom Betlach

Director, AHCCCS



Christina Corieri

Senior Policy Advisor, Office of Governor Doug Ducey