Issue: AZ Healthcare

Unaffordable Healthcare in Arizona

Current Status of Healthcare

As the pandemic rages, private healthcare insurance continues to be unaffordable. More than half of Arizonans are uninsured or use government-related health insurance programs. As of 2020, Arizona ranked a dismal 43rd nationally in affordability and accessibility and 33rd in healthcare system performance.[1] As of 2018, one out of ten Arizonans had no health insurance,[2] and Arizona ranked 3rd worst state in the country for the percentage of uninsured children.[3] Instead of finding ways to provide healthcare insurance to all Arizonans, Republican lawmakers actively work to restrict access.

Before the COVID-19 Pandemic

Data from 2018 compiled by the Kaiser Family Foundation show the distribution of various types of healthcare insurance among the overall Arizona population.[4]

Uninsured	Medicare	Medicaid	Non-Group (privately purchased)	Military	Employer
11%	16%	22%	5%	1%	44%

The above table reveals that in 2018 *more than half* of all the people in Arizona were either uninsured or obtained insurance through a government-administered, government-funded program (Medicare; Medicaid; subsidized policies through the Affordable Care Act (ACA) private insurance exchange, which is a subset of non-group; and the military). Resistance to a public option defies the obvious need—given the number of people already using a publicly-funded program, the number who still need government assistance to afford the high cost of healthcare insurance, and polls showing that the majority of Americans favor a public option.[5]

Uninsured

In 2013 the uninsured rate for Arizona was 17 percent. That rate declined to 10 percent in 2016, just two years after the ACA exchange was established.[6] The rate rose again, however, to almost 11 percent in 2018, with approximately 750,000 Arizonans uninsured,[7] including 146,000 children.[8] With an uninsured rate of 8.4 percent for children, Arizona ranked 3rd worst in the U.S.[9] Racial and ethnic disparities are also significant, as the uninsured rate was 20 percent for the Latinx population and 23 percent for Native Americans from 2013 to 2017.[10]

Medicare

In 2018 approximately 1.3 million people in Arizona were enrolled in Medicare.[11] That number is expected to grow significantly as the state population ages.[12]

Medicaid

The state Medicaid program is called the Arizona Health Care Cost Containment System (AHCCCS). Individuals and families are eligible for Medicaid if the household income is at or below 138 percent of the federal poverty level (FPL).[13] If the family income exceeds that level but is less than 205 percent of the FPL, the children in the family can qualify for an AHCCCS program called KidsCare, which is the name of the Children's Health Insurance Program (CHIP) in Arizona.[14]

In December 2018, enrollment in the state Medicaid programs hovered around 1.7 million, an increase of 500,000 people covered since Medicaid was expanded under the ACA in 2013.[15] In 2018, 40 percent of children in Arizona received health insurance through AHCCCS.[16] As of July 2020, total Medicaid enrollment spiked to 2 million—*more than 27 percent of the Arizona population*.[17]

ACA Subsidies

People who are not eligible for Medicaid but who earn between 100 to 400 percent of the FPL can qualify for subsidies to reduce their monthly premiums when they purchase private health insurance plans through the ACA exchange.[18] In 2018, 65 percent of the population in Arizona had annual incomes below 400 percent of the FPL.[19]

	Individual	Family of 2	Family of 3	Family of 4	% of AZ population
FPL in 2018[20]	$12,140	$16,460	$20,780	$25,100	14%
101% - 200% FPL	$24,280	$32,920	$41,560	$50,200	20%
201% - 400% FPL	$48,560	$65,840	$83,120	$100,400	31%

In 2019 in Arizona, 160,456 people enrolled in a private ACA plan. Of those, 84 percent qualified for federal subsidies.[21]

Private Insurance

A "benchmark plan" is the health insurance plan that a state uses to define essential benefits for individual and small group policies (usually the second-lowest silver-tier plan on the ACA exchange).[22] Without the ACA subsidy, the combined premiums and deductible amounts are unaffordable for most people.

For individuals, the average benchmark monthly premium in Arizona in 2018 was $516—about $6200 per year.[23] The national average deductible on individual plans in 2018 was almost $4600.[24] Given that the median per capita income in Arizona was $30,530 in 2018,[25] the total cost of premiums plus deductible (almost $10,800) would constitute *more than one-third* of an individual's gross income.

For families, the national average premium for a benchmark plan in 2018 was about $1,200 per month, or $14,400 annually.[26] The national average deductible on family plans was about $8,800.[27] The potential total cost of over $23,000 would be *more than one-third* the median household gross income of $59,246 in Arizona in 2018.[28]

After the Onset of the COVID-19 Pandemic

In July 2020, Arizona experienced the worst COVID-19 outbreak in the country. Republican Governor Doug Ducey waited too long to impose contagion-prevention measures after the initial wave and then re-opened the economy too soon and too rapidly in May. He even downplayed the threat, encouraging people to shop and dine out, and he prohibited local governments from requiring masks in their own cities and towns. When cases started rising again, Ducey once more was too slow to respond, which led to the surge of infections in June and July.[29] The mishandling of the pandemic has had a significantly negative impact on healthcare coverage in Arizona.

Higher Uninsured Levels

Between February and May, 5.4 million Americans lost their health benefits when they lost their jobs due to the mishandling of the pandemic. Among that group were 47,000 Arizonans. Now 17 percent of all adults under the age of 65 in Arizona are uninsured. Because uninsured people are reluctant to seek treatment, they are less likely to know that they are infected with COVID-19 and more likely to spread the virus to others. Lack of insurance can also lead to higher death rates from delaying or never receiving medical care or to massive medical bills and bankruptcy for those who do.[30]

Workers who have lost their employer-sponsored health insurance can temporarily extend their plans by signing up for COBRA (Consolidated Omnibus Reconciliation Act). They can also obtain a new insurance policy through the ACA exchange because the involuntary loss of a job is a qualifying event beyond the open enrollment period. Neither option is realistic, though, since unemployed workers will likely find it difficult to pay premiums without an income. Therefore, Medicaid may be their only option, as long as they meet the income-level requirements.[31]

For those who did not have insurance before the pandemic, some state-run ACA exchanges offered special enrollment periods allowing people to obtain subsidized health insurance even without a qualifying event. However, Arizona uses the federal health insurance exchange (HealthCare.gov), and the Trump administration refused to open a special ACA enrollment period during the COVID-19 health crisis.[32] Therefore, Arizonans who were uninsured before the pandemic cannot get insurance unless they can either afford to pay the full premium on a private plan outside of the ACA exchange or qualify for Medicaid.

Higher Medicaid Enrollment

Enrollment in Arizona's Medicaid program hit an all-time high of 2 million in July, and that figure is expected to rise. The increase is attributable to two factors—the rise in unemployment and the federal freeze on Medicaid disenrollment. More people are qualifying for Medicaid after having lost their income and their employer-sponsored health benefits during the pandemic. In addition, the federal relief funding comes with the condition that states must continue to provide services during the pandemic to anyone already enrolled in Medicaid despite changes in their eligibility.[33]

In March Congress passed the Families First Coronavirus Relief Act (FFCRA), which temporarily increased the federal government's share of Medicaid costs by 6.2-percentage points. States receiving this additional funding are prohibited from cutting benefits, increasing premiums, or raising eligibility requirements for new enrollees, and they must continue to provide coverage for all existing and new enrollees until the Public Health Emergency (PHE) declaration expires[34] (currently

October 23, 2020[35]). The intent is to avoid kicking vulnerable people off Medicaid and leaving them without access to medical services during the pandemic in the event an increase in income puts them above the eligibility cutoff.

However, the FFCRA increase is not enough. In 2009 (a period of recession *without* a pandemic), Congress authorized almost twice as much for temporary Medicaid relief. Now, while state revenues are plunging from the economic downturn, Medicaid costs are rising not only from higher enrollment due to job losses, but also from the additional costs of COVID-19 testing and treatment.[36]

In May, the National Association of Medicaid Directors (NAMD) and the National Governors Association called for Congress to increase the federal government's share of Medicaid funding to states by an additional 5.2 percentage points. The Democrats also attempted to legislate an increase of 7.8 percent, but Republican Senator Mitch McConnell rejected that proposal and has repeatedly refused considering sending states more money.[37]

Of particular concern is the impact on children, since 40 percent of children in Arizona rely on Medicaid and KidsCare. Already immunizations are down nationally and statewide. The CDC reported "a notable decrease" in vaccinations, especially among children between the ages of 2 and 18.[38] The largest healthcare provider in Arizona reported a 12-percent decline in child vaccinations, and a survey of members of the Arizona chapter of the American Academy of Pediatricians showed a 70- to 80- percent decline in pediatric visits. Unvaccinated children raise the risk of an outbreak of a variety of infectious diseases, including measles.[39]

Since federal law requires states to balance their budgets, states will eventually be forced to either raise taxes or make Medicaid program cuts. Typically, in times of economic distress, states cut Medicaid reimbursement rates.[40] Medicaid providers are already financially vulnerable because they typically receive lower reimbursement rates and have lower operating margins. Now during the pandemic, they have lost revenue because patients are not coming in for regular care, and they have incurred additional COVID-related expenses. Without adequate funding, clinics and other facilities that rely on Medicaid will have to curtail services or close, resulting in fewer providers when more are needed during a national health crisis.[41]

In March, as an emergency response to the COVID-19 pandemic, the Arizona legislature passed HB 2668, a hospital assessment to fund higher reimbursement rates for Medicaid physicians and dental care providers and interim payments to Medicaid-enrolled hospitals during the health crisis.[42] However, this solution is not sustainable. The temporary 6.2-percent raise in the federal share of Medicaid costs and the accompanying disenrollment freeze will disappear after the public health emergency is lifted. The economic recovery period will continue far beyond that date, and severe state shortfalls are expected in the next fiscal year.

Nationwide, states are expected to experience an increase in Medicaid and CHIP enrollments while state revenues fall. Increasing the federal share of Medicaid costs (FMAP—Federal Medical Assistance Percentage) reduces the state's share. The following report discusses various policy proposals for raising the FMAP and the resulting impact on each state:
https://www.urban.org/sites/default/files/publication/102098/increasing-federal-medicaid-matching-rates-to-provide-fiscal-relief-to-states-during-the-covid-19-pandem_0.pdf

Higher Medicare Costs

Medicare serves an older population with higher rates of chronic health conditions—the population most vulnerable to COVID-19. Therefore, Medicare spending is expected to rise. Additional costs include increases in hospitalizations, the need for ventilators and ICU treatment, post-hospital care in nursing homes or from home healthcare providers, and medications. At the same time that costs are climbing, the amount collected from payroll taxes (the main source of funding for Medicare) is expected to drop due to the surge in unemployment caused by the pandemic. To offset the shortfall between income and expenses, all Medicare beneficiaries are likely to face higher out-of-pocket costs for premiums, deductibles, and other cost-sharing requirements in the future.[43]

Higher ACA Exchange Premiums

Given the uncertainties of the COVID-19 health crisis, insurers are hard-pressed to set realistic premiums for next year. The rates from insurers planning to participate in the ACA exchange during the next open enrollment period are not yet publicly available. However, a report on preliminary filings in 10 states and D.C. shows proposed premiums ranging from a 12-percent decrease to an increase of almost 32 percent. Most range from a 2-percent decrease to a 6-percent increase. Insurers will likely revise their proposals as the pandemic evolves, factoring in such variables as the spread of the virus, the impact on hospital costs, the outlook for a vaccine, and economic conditions.[44]

Alternatives and Reforms: Good and Bad

Medicaid Buy-In: Lower-Cost Public Option

To provide an affordable healthcare option, many states are considering allowing individuals to buy into the state Medicaid program. Enrollees would pay premiums and possibly cost-sharing charges, such as co-pays and deductibles. In 2019, legislation to study or adopt a Medicaid buy-in was introduced in more than 10 states.[45]

In 2018 Democrats introduced legislation (HB 2443) to establish a Medicaid buy-in program in Arizona. The enrollee would have had to be uninsured for six months prior to enrollment and would have had to pay the full cost of coverage, including the full premium price, co-pays, and deductibles. The bill also expressly prohibited the use of state monies to administer the program.[46] According to the sponsors, the program would appeal to individuals who did not have insurance through their employers and whose income was too high for ACA premium subsidies but too low to afford the full cost of private insurance. Small businesses would also be interested in such a program.[47] The bill was assigned to the Republican-controlled House Rules and the House Health committees but was never given a hearing in either committee.[48] In 2020, the Democrats introduced the same bill (this time as HB 2427), but it suffered the same fate.[49]

The specific design and terms of Medicaid-buy-in programs can vary widely, depending on the state's policy objectives, target population, and market conditions. Generally, though, they are patterned on one of the following three models:[50]

1. **Basic Health Program (BHP)**
   The ACA allows states to offer BHPs, through which individuals can pay to be covered by the existing Medicaid program if their incomes are below 200 percent of the FPL but too high to qualify for Medicaid. Many in this target population are parents of children enrolled in

KidsCare. Often, they are in and out of the Medicaid program because their low incomes fluctuate around the Medicaid cutoff level, so BHPs allow continuity of care for this group. Individuals are assessed premiums and cost-sharing fees. The federal government pays the state 95 percent of the subsidies for which these individuals would have been eligible if they had purchased an insurance plan through the ACA exchange.[51]

2. **Qualified Health Plan (QHP) on the ACA exchange**
   A state-sponsored QHP offered through the ACA exchange is another example of a Medicaid buy-in. Because the state insurance plan would use the existing Medicaid infrastructure, premiums and cost-sharing charges would be lower. As long as it meets all ACA standards, the state QHP would qualify for the federal premium subsidies as a source of funding. However, any variation from the ACA standards (such as differences in essential benefits or different limits on deductibles and co-pays) would force the state to submit a waiver for federal approval, which is unlikely during a Republican administration. Under ACA rules, plans on the exchange must be offered by state-licensed issuers, so the state would need to submit another waiver if it wanted to issue the plan directly on the exchange. To avoid this waiver, the state could contract with its partnering Medicaid managed care organizations (MCOs) to issue the state QHP.[52] MCOs are networks of doctors and hospitals that accept Medicaid patients for a set per-patient annual fee paid by the state.[53]

3. **Off-exchange buy-in**
   If not sold on the exchange, a Medicaid buy-in plan would not have to meet ACA requirements. The state could offer enrollment into existing Medicaid programs, or it could develop a new Medicaid-style program and set the premiums, cost-sharing contributions, eligibility guidelines, and benefits independently. However, obtaining federal pass-through funds would require a waiver. The state would have to ask the federal government to pass on to the state the amount saved from federal subsidies that would have been paid out if the individual had enrolled in a private plan on the ACA exchange. Again, approval would be unlikely during a Republican administration. Therefore, funding would have to come from enrollee-paid premiums and cost-sharing contributions and/or state revenues.[54]

Public options are less costly than private plans for many reasons, including:

- Public insurance plans are not for profit.
- Leveraging the Medicaid infrastructure lowers administrative costs.
- Medicaid reimbursement rates to medical providers are lower than private reimbursement levels. (To assuage providers, lower reimbursement rates might be offset by lower rates of uncompensated care, i.e., unpaid bills incurred by uninsured patients.)
- Economies of scale give the state better purchasing and negotiating power.
- More competition in the marketplace reduces costs.
- Higher enrollment diversifies the risk pool.[55]

Below are links to studies about Medicaid buy-in proposals in four states:

Colorado	https://www.manatt.com/getmedia/21be89cc-b059-4af7-a458-2c6b2801ea21/Manatt-Health_A-Promising-Strategy-for-an-Affordable-Medicaid-Buy-In-Opt
Delaware	https://news.choosehealthde.com/wp-content/uploads/2019/01/SCR-70-Medicaid-Buy-In-Study-Group-Final-Report-01.15.19.pdf

Massachusetts	https://www.mahealthconnector.org/wp-content/uploads/Medicaid-Buy-in-Study-10-22-2018.pdf
New Mexico	https://www.manatt.com/Manatt/media/Documents/Articles/Evaluating-Medicaid-Buy-in-Options-for-New-Mexico.pdf

Junk Plans: No Consumer Protections

The Trump administration has been touting short-term, limited-duration plans (STLDs), otherwise known as "junk plans." Junk plans are lower-cost, high-deductible insurance policies that don't provide the essential benefits or the consumer protections required by the ACA. Originally, enrollment in a short-term plan was limited to three months. It was intended as a stopgap measure to provide catastrophic coverage during transition periods, such as being between jobs. In 2018 the Trump administration adopted new rules allowing enrollment in STLDs for up to three years.[56] Republican legislators in Arizona codified the Trump rules into state law in 2019 by passing SB 1109.[57]

Cheap plans are attractive to healthy people who do not want to pay for insurance that they are likely not to use. However, if the enrollee does need medical care, these short-term plans do not provide adequate coverage and result in extremely high out-of-pocket expenses that can end in bankruptcy for the consumer. A report by the U.S. House of Representatives Committee on Energy and Commerce called STLDs "a threat to the health and financial well-being of American families."[58]

Junk plans do not cover pre-existing conditions, and they generally do not cover prescription drugs, maternity care, behavioral health treatment, and other essential services. Deductibles are very high. In one study, the STLDs required enrollees to pay $10,000 to $12,500 before the insurer started paying even a portion of the medical bills. Sometimes such policies have separate deductible amounts for ER bills. The insured person is also more likely to incur "surprise" bills from ER visits or from hospitalizations because STLDs do not use a network of providers; instead they cover amounts that the insurer deems to be "reasonable and customary." Providers then turn around and bill the patient for the balance.[59]

The pitfalls of short-term plans are even more dangerous during the COVID-19 pandemic, and investigations have revealed that consumers are being misled about the coverage for COVID-19-related expenses. Confusing online ads direct shoppers to junk plans, and representations made by sales agents are not supported by the plan documents. Salespeople overstate the coverage for COVID-19 testing and treatment, including the amount for an expensive hospitalization. Prescription drugs to treat symptoms and complications from the virus are not covered, and some plans do not cover preventative care, which could include a COVID-19 vaccine. If the consumer is infected with COVID-19 before the STLD plan goes into effect, even if the enrollee has not been diagnosed, expenses for testing and treatment could be denied as a preexisting condition.[60]

Because STLDs do not comply with ACA standards, they cannot be offered on the ACA exchange. As a result, they lure healthier Americans away from the ACA program, making the ACA risk pool smaller and sicker, which increases premiums on ACA policies.[61]

Reinsurance: Lower Premiums

Basically, reinsurance is insurance for insurance companies. It helps keep premiums down by protecting insurers from insolvency if they enroll too many people with exorbitant medical costs. The ACA included a temporary reinsurance program to stabilize premiums during its initial stages (from 2014 to 2016). The purpose was to dissuade insurers from setting high premiums as a cushion against the unknown impact of enrolling people with preexisting conditions.[62] All insurers in the ACA exchange paid into a reinsurance fund administered by Health and Human Services (HHS). HHS then paid out to participating insurers when they incurred claims that exceeded a certain amount, up to a maximum.[63] Since that program ended in 2016, fourteen states have created their own reinsurance programs (twelve already in place, two more effective as of 2021).[64]

In spring 2020, two proposed state bills would have authorized the Arizona Department of Insurance to conduct a financial analysis of the potential effects of reinsurance in Arizona.[65] The Democratic-sponsored bill (HB 2425) was assigned to the House Rules Committee but did not get a committee vote.[66] The Republican-sponsored bill (SB 1213) was passed by the Senate but stalled after that.[67]

In the most common state model, the insurer is responsible for every claim up to a threshold level. If a claim exceeds the threshold, reinsurance pays a portion of the amount between the threshold level and a ceiling level. If the total claim exceeds the ceiling level, the insurer is responsible for the amount beyond the ceiling. The less common model is based on medical diagnoses. Reinsurance pays a portion of claims for the treatment of certain high-cost medical conditions.[68]

To finance their reinsurance programs, some states have adopted individual mandate laws with revenue-generating state-tax penalties for noncompliance. Other states use general fund revenues. However, most states use ACA waivers to obtain federal pass-through funds. Because reinsurance covers a portion of patient medical bills, the insurer does not have to pay out as much. As a result, the insurer has lower costs, which means that the insurer can charge lower premiums. Lower premiums mean lower federal ACA premium subsidies. Rather than keep the savings, the waiver asks the federal government to pass that subsidy differential on to the state for its reinsurance program.[69] Regardless of the funding source, reinsurance has helped to keep premiums in check in those states.[70] Lower premiums attract more consumers, and the combination of lower premiums and higher enrollment makes for a more stable healthcare insurance market.[71]

Republican Restrictions on Access to Healthcare

Medicaid

Arizona became the last state in the union to provide healthcare for the poorest of citizens when it implemented its Medicaid program in 1982. In 2013 Arizona joined 37 other states and D.C. to expand Medicare eligibility requirements under the ACA to provide healthcare for more of its low-income residents.[72] Under the ACA the federal government covered 100 percent of the costs of the expanded Medicaid population for the first three years, and 90 percent thereafter.[73] Nevertheless, Republican lawmakers have been fighting to curtail the Medicaid program ever since. The following is a brief chronology of some of those efforts:

- **2010 Federal lawsuit opposing Medicaid expansion:** Under the Affordable Care Act enacted in 2010, if a state did not expand Medicaid eligibility to include anyone with incomes below 138 percent of the federal poverty level, it would lose all its federal Medicaid funds.

Arizona joined a federal lawsuit filed in March 2010 challenging the constitutionality of the law. In June 2012, the U.S. Supreme Court decided that the expansion of the program was permissible, but the denial of all Medicaid funding was unconstitutionally coercive. Therefore, Medicaid expansion had to be conducted on a voluntary basis.[74]

- **2013 Most Republicans voted against expansion:** In what was considered a surprising turn of events, Republican Governor Jan Brewer aggressively pushed for the expansion of Medicaid in Arizona. Opposition came only from Republican legislators. The law passed in July 2013 by a vote of 18 (13D, 5R) to 11 (all R) in the state Senate and a vote of 33 (24D, 9R) to 27 (all R) in the state House.[75]

- **2014 State lawsuit opposing expansion:** Thirty-six of the Arizona Republican lawmakers who voted against Medicaid expansion filed a lawsuit to declare illegal the assessment on hospitals to fund the state's portion of the expansion. They claimed that the assessment was really a tax, which requires approval of two-thirds of the legislature instead of a simple majority vote. They lost.[76]

- **2015 Medicaid waiver for work requirements:** The Republican legislature passed SB 1092 requiring the state to submit annual waivers to the federal government asking for more restrictive Medicaid eligibility requirements. The objective was to make Medicaid temporary for able-bodied adults despite their poverty, while maintaining long-term benefits only for children and the disabled. The new Republican Governor, Doug Ducey, submitted a waiver proposal with a work requirement, a five-year lifetime limit on benefits, and co-pays for able-bodied adults.[77]

- **2016 Obama rejected waiver:** The Obama administration rejected most of Ducey's proposal, including the work requirement, but approved requirements for small contributions to health savings accounts and voluntary participation in job search programs in order to retain eligibility.[78]

- **2019 Trump approved waiver:** The Trump administration approved Ducey's waiver request that able-bodied adults between the ages of 19 and 49 be required to work or participate in job training or school at least 80 hours a month and regularly report compliance to the state in order to receive Medicaid benefits. These requirements ignore the obstacles faced by most low-income people—limited skills and education, jobs that pay less than their childcare costs, problems navigating the bureaucracy, lack of transportation, etc. However, Arizona has postponed the implementation of this policy pending the outcome of litigation involving challenges to similar work requirements in other states. The Trump administration rejected Arizona's proposed five-year limit on benefits.[79]

KidsCare

- **2010 Enrollment freeze:** The legislature froze enrollment in KidsCare, the state program funded by the federal Children's Health Insurance Program (CHIP) covering children in families with incomes less than 205 percent of the FPL.
- **2014 Program dismantled:** The legislature discontinued KidsCare, making Arizona the only state without a CHIP program for two years, until it was re-established in 2016.[80]
- **2017 Trigger for new freeze:** The legislature adopted language to trigger an immediate enrollment freeze in KidsCare if the federal contribution fell below 100 percent.[81]

- **2019 Discretionary freeze:** The legislature removed the "trigger" language and instead gave the AHCCCS director the authority to freeze enrollment if federal and state appropriations are insufficient.[82]

ACA Exchange

In Arizona the highest enrollment and the highest number of participating insurers in the ACA occurred in 2015 (one year after the establishment of the program).[83] Declines since then can be attributed in large part to Republican efforts to undermine the program. Despite these obstacles, the ACA has proven resilient, and the number of insurers in Arizona has been rising.[84] Below is a chronology of just a few of the Republican attacks on the ACA.

- **2010 Federal lawsuit to overturn the ACA:** Enacted in March 2010, the ACA contained an individual mandate—a requirement that every person be enrolled in a health insurance plan or incur a tax penalty.[85] The purpose was to widen the risk pool to keep insurers' costs manageable. When everyone pays for insurance, the contribution from healthy people who incur fewer costs for medical services offsets the higher costs incurred by sicker people. That balance allows insurers to keep premiums lower for all.[86] Very shortly after the ACA was adopted, Arizona joined a federal lawsuit (*NFIB v. Sebelius*) to overturn the ACA, including the individual mandate. In 2012 the U.S. Supreme Court deemed the individual mandate to be constitutional.[87]

- **2014 ACA risk-management feature eliminated:** The ACA prevents insurers from rejecting or overcharging people with pre-existing health conditions and provides premium subsidies for low- and middle-income enrollees. To address these costs, the ACA included regulatory measures—risk corridors, risk adjustment, and reinsurance. Those features were meant to act in concert to stabilize the market and keep premiums down by re-distributing the costs of higher-risk, sicker people more equitably among insurers. In particular, use of risk corridors was a method for transferring funds from insurers who had lower-than-expected claims to insurers who experienced higher-than-expected claims.[88] In 2014 Republican Senator Marco Rubio included in a congressional spending bill a provision that severely curtailed the risk corridor mechanism. Insurers received only 13 percent of what they were expecting from the government, causing many to fail.[89]

- **2015 No AZ state exchange:** Republican lawmakers passed HB 2643 prohibiting the state from establishing an ACA insurance exchange in Arizona. A pending federal lawsuit at that time (*King v. Burwell*) sought a decision that ACA subsidies were valid only for plans offered by state-operated exchanges. The U.S. Supreme Court later that year decided that subsidies were valid in all states, including states like Arizona that use the federal Healthcare.Gov exchange.[90]

- **2017 McSally votes to repeal ACA:** A vote to repeal the ACA passed in the Republican-controlled U.S. House of Representatives but failed in the U.S. Senate. Republican Martha McSally and Democrat Kyrsten Sinema were members of the House representing Arizona at that time. McSally voted to repeal the ACA; Sinema voted to retain it.[91]

- **2017 Individual-mandate tax penalty repealed:** Congressional Republicans repealed the tax penalty for the individual mandate, effective as of 2019. The mandate still stands, but without the penalty, healthy individuals have less incentive to pay for insurance they don't

expect to need. Without those healthy enrollees, the risk level of the remaining enrollee pool is higher, which drives up premiums.[92]

- **2017 Enrollment sabotage:** The Trump administration instituted policy changes to sabotage ACA enrollment—shrinking the enrollment period on the federal exchange from three months to six weeks, cutting by 90 percent the community outreach funding to advertise the program, and reducing by 40 percent the funding for navigators who assist people during the enrollment process.[93] Lower enrollment restricts the risk pool and drives up premiums.

- **2018 Junk plans:** The Trump administration expanded the availability of short-term "skimpy" health insurance plans—lower-cost, high-deductible insurance policies that don't provide the essential benefits required by the ACA. Such plans attract healthy people away from the ACA exchange, resulting in higher premiums for ACA plans.[94] In 2019 Democrats forced a Senate floor vote on a resolution opposing Trump's policy. The two U.S. Senators from Arizona were split on the issue. Republican Senator McSally voted to support the proliferation of Trump's junk plans, while Democratic Senator Sinema voted to curtail them.[95] In 2019 Republican lawmakers in Arizona passed SB 1109, which aligned Arizona's rules on short-term insurance plans with those of the Trump administration.[96]

- **2018 Second Supreme Court challenge to overturn ACA:** Arizona joined 17 other states and the Trump administration in a federal lawsuit (*California v. Texas*) aimed at ending the ACA entirely. The U.S. Supreme Court will hear oral arguments on November 10, 2020. In the 2010 lawsuit *NFIB v. Sebelius* the U.S. Supreme Court declared the individual mandate constitutional based on the federal government's power to tax. In *California v. Texas,* the plaintiffs argue that the individual mandate is no longer constitutional because the tax penalty was eliminated in 2017. Since the mandate no longer generates tax revenue, it cannot be justified as an exercise of the federal government's constitutional power to tax. The plaintiffs also argue that the individual mandate provisions cannot be severed from the rest of the ACA so the entire law must be invalidated, including the protections for people with pre-existing conditions. If so, more than 23 million Americans will lose their healthcare.[97]

- **2020 Meaningless protections for preexisting conditions:** State-level bills sponsored by Republicans purporting to protect people with pre-existing conditions are charades. Arizona Republicans are part of the lawsuit trying to dismantle the ACA, which not only prevents insurers from rejecting people with preexisting conditions, but also prohibits them from charging exorbitant premiums for that vulnerable group. The new Arizona state law sponsored by Republicans (SB 1397) prevents insurers from excluding people with preexisting conditions but does nothing to limit the price of their premiums.[98] Republicans would not even allow a floor discussion of the competing Democratic proposal, which would have prevented insurers from basing premiums on a person's health status.[99]

- **2020 No Republican replacement for ACA:** For years Republicans have promised to replace the ACA, but they have failed to deliver a comprehensive healthcare plan of their own.[100]

Medicare

Access to healthcare for older Americans is at risk due to demographic changes and potential Republican tax cuts. Medicare is primarily funded by payroll taxes. While Americans are living longer,[101] birth rates in the U.S. have been declining since the 1960s.[102] More people are enrolling in the program, while fewer working-age people are paying into the Medicare fund.[103] That means higher costs, less money. Yet the Republican president has promised to cut payroll taxes.

Projections indicate that the number of people on Medicare will rise from 54 million in 2014 to 93 million in 2050, while the ratio of workers to Medicare recipients will fall from 3.2 to 2.3.[104] In Arizona the number of residents age 65 and up is expected to almost triple—from about 880,000 in 2010 to 2.4 million in 2050. Forecasters predict that by 2025 the number of people over 65 in Arizona will equal the number under age 15.[105]

In August, as an attempt to stimulate the economy during the pandemic, President Trump signed an executive order temporarily deferring the payment of some payroll taxes. About 30 major industry groups, including the U.S. Chamber of Commerce, stated that businesses most likely will not implement the deferral plan because it is not practicable.[106] However, Trump's action may be a harbinger of things to come. In fact, while signing the executive order, he promised to pursue *permanent* cuts in payroll taxes if re-elected. Medicare funding is already precarious.[107] Reducing or eliminating payroll taxes would endanger the viability of the program, thus directly endangering the lives of the millions of senior citizens living in Arizona.

Conclusion

Too many people in Arizona are uninsured. Without an employer-sponsored plan or a government-subsidized program, the majority of people cannot afford healthcare insurance. Congressional Democrats have made healthcare a top priority and have passed legislation to expand healthcare to millions of Americans. Conversely, Congressional Republicans have repeatedly promised an alternative comprehensive health insurance plan that has never materialized. Arizona Democrats have proposed state legislation to create a public option and explore programs that could reduce premiums. In contrast, Arizona Republicans have focused their efforts on overturning the ACA, restricting Medicaid eligibility, freezing or eliminating KidsCare, and promoting junk plans that leave consumers unprotected and vulnerable to financial ruin. Most egregious of all, Republican policies restrict access to healthcare at a time when it is most needed—during a global pandemic.

Source Notes

Current Status of Healthcare

[1] https://2020scorecard.commonwealthfund.org/state/arizona
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