REFERENCE TITLE: health care; 2026-2027

State of Arizona
House of Representatives
Fifty-seventh Legislature
Second Regular Session
2026

HB 4160

Introduced by
Representatives Livingston: Carbone, Carter N, Montenegro, Willoughby
(with permission of Committee on Rules)

AN ACT

AMENDING SECTION 36-798.51, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2920.01; AMENDING SECTIONS 38-651 AND 38-654, ARIZONA REVISED STATUTES; AMENDING TITLE 38, CHAPTER 4, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 38-655; APPROPRIATING MONIES; RELATING TO HEALTH CARE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-798.51, Arizona Revised Statutes, is amended to read:

36-798.51. Overdose and disease prevention programs; requirements; standards; prohibition on use of opioid settlement monies

A. A city, town, county or nongovernmental organization, including a local health department or an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, or any combination of these entities, may establish and operate an overdose and disease prevention program. A program established pursuant to this section shall have all of the following objectives:

1. To reduce the spread of viral hepatitis, HIV and other bloodborne diseases in this state.

2. To reduce needle-stick injuries to law enforcement officers and other emergency personnel.

3. To encourage individuals who inject drugs to enroll in evidence-based treatment.

4. To increase proper disposal of used syringes.

5. To reduce the occurrence of skin and soft tissue wounds and infections related to injection drug use.

B. A program established pursuant to this section shall offer all of the following:

1. Disposal of used needles and hypodermic syringes.

2. Needles, hypodermic syringes and other injection supply items at no cost and in quantities sufficient to ensure that needles, hypodermic syringes and other injection supply items are not shared or reused.

3. Educational materials on all of the following:

(a) Overdose prevention.

(b) Peer support services.

(c) The prevention of HIV, viral hepatitis transmission and the incidence of skin and soft tissue wounds and infections.

(d) Treatment for mental illness, including treatment referrals.

(e) Treatment for substance use disorder, including referrals for substance use disorder treatment.

4. Access to kits that contain naloxone hydrochloride or any other opioid antagonist that is approved by the United States food and drug administration to treat a drug overdose, or referrals to programs that provide access to naloxone hydrochloride or any other opioid antagonist that is approved by the United States food and drug administration to treat a drug overdose.

5. For each individual who requests services, personal consultations from a program employee or volunteer concerning mental health or substance use disorder treatment or referrals for evidence-based substance use disorder treatment, as appropriate.

C. A program established pursuant to this section shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. The number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program.

D. A CITY, TOWN OR COUNTY MAY NOT USE MONIES RECEIVED THROUGH THE FINAL ONE ARIZONA DISTRIBUTION OF OPIOID SETTLEMENT FUNDS AGREEMENT TO PROVIDE OR TO GRANT MONIES TO A NONGOVERNMENTAL ORGANIZATION TO PROVIDE SAFER SMOKING EQUIPMENT. FOR THE PURPOSES OF THIS SUBSECTION, "SAFER SMOKING EQUIPMENT" MEANS STERILE, DURABLE AND SPECIALIZED TOOLS INTENDED TO REDUCE THE HEALTH RISKS ASSOCIATED WITH INHALING DRUGS, SUCH AS COCAINE BASE, METHAMPHETAMINE OR OPIOIDS.

Sec. 2. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2920.01, to read:

36-2920.01. Arizona rural health transformation fund; public meetings

A. THE ARIZONA RURAL HEALTH TRANSFORMATION FUND IS ESTABLISHED CONSISTING OF MONIES RECEIVED BY THIS STATE THROUGH THE RURAL HEALTH TRANSFORMATION PROGRAM PRESCRIBED IN SECTION 71401 OF PUBLIC LAW 119-21. THE ADMINISTRATION SHALL ADMINISTER THE FUND. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED.

B. BEFORE THE EXECUTIVE BRANCH MAY SPEND ANY OF THE MONIES IN THE ARIZONA RURAL HEALTH TRANSFORMATION FUND, THE ADMINISTRATION SHALL HOLD THREE PUBLIC MEETINGS IN EACH OF THE LARGEST METROPOLITAN AREAS IN NORTHERN, CENTRAL AND SOUTHERN ARIZONA TO RECEIVE INPUT AND FEEDBACK REGARDING HOW THE MONIES SHOULD BE SPENT AND SHALL SUBMIT A REPORT TO THE JOINT LEGISLATIVE BUDGET COMMITTEE DETAILING ITS EXPENDITURE PLAN FOR THE MONIES RECEIVED THROUGH THE RURAL HEALTH TRANSFORMATION PROGRAM PRESCRIBED IN SECTION 71401 OF PUBLIC LAW 119-21.

Sec. 3. Section 38-651, Arizona Revised Statutes, is amended to read:

38-651. Expenditure of monies for health and accident coverage; definition

A. The department of administration may ~~expend~~ SPEND public monies appropriated for such purpose to procure health and accident coverage for full-time officers and employees of this state and its departments and agencies. The department of administration may adopt rules that provide that if an employee dies while the employee's surviving spouse's health insurance is in force, the surviving spouse is entitled to ~~no~~ NOT more than thirty-six months of extended coverage at one hundred two ~~per cent~~

PERCENT of the group rates by paying the premiums. Except as provided by sections 38-1114 and 38-1141, ~~no~~ public monies may NOT be ~~expended~~ SPENT to pay all or any part of the premium of health insurance continued in force by the surviving spouse. The department of administration, IN CONSULTATION WITH THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD ESTABLISHED BY SECTION 38-655, shall seek a variety of plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations. On ~~a~~ THE recommendation of the department of administration and the review of the joint legislative budget committee, the department of administration may self-insure for the purposes of this subsection. If the department of administration self-insures, the department, FOLLOWING APPROVAL BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD, may contract directly with preferred provider organizations, physician and hospital networks, indemnity health insurers, hospital and medical service plans, dental plans and health maintenance organizations. If the department self-insures, the department shall provide that the self-insurance program include all health coverage benefits that are mandated pursuant to title 20. The self-insurance program shall include provisions to provide for the protection of the officers and employees, including grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues. The department of administration, by rule AND FOLLOWING APPROVAL BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD, shall designate and adopt performance standards, including cost competitiveness, utilization review issues, network development and access, conversion and implementation, report timeliness, quality outcomes and customer satisfaction for qualifying plans. The qualifying plans for which the standards are adopted include indemnity health insurance, hospital and medical service plans, closed panel medical and dental plans and health maintenance organizations, and for eligibility of officers and employees to participate in such plans. Any indemnity health insurance or hospital and medical service plan designated as a qualifying plan by the department of administration AND APPROVED BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD must be open for enrollment to all permanent full-time state employees, except that any plan established ~~prior to~~ BEFORE June 6, 1977 may be continued as a separate plan. Any closed panel medical or dental plan or health maintenance organization designated as the qualifying plan by the department of administration AND APPROVED BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD must be open for enrollment to all permanent full-time state employees residing within the geographic area or area to be served by the plan or organization. Officers and employees may select coverage under the available options.

B. The department of administration may ~~expend~~ SPEND public monies appropriated for such purpose to procure health and accident coverage for the dependents of full-time officers and employees of this state and its

departments and agencies. The department of administration shall seek a variety of plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations. On ~~a~~ THE recommendation of the department of administration and the review of the joint legislative budget committee, the department of administration may self-insure for the purposes of this subsection. If the department of administration self-insures, the department, FOLLOWING APPROVAL BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD, may contract directly with preferred provider organizations, physician and hospital networks, indemnity health insurers, hospital and medical service plans, dental plans and health maintenance organizations. If the department self-insures, the department shall provide that the self-insurance program include all health coverage benefits that are mandated pursuant to title 20. The self-insurance program shall include provisions to provide for the protection of the officers and employees, including grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues. The department of administration, by rule AND FOLLOWING APPROVAL BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD, shall designate and adopt performance standards, including cost competitiveness, utilization review issues, network development and access, conversion and implementation, report timeliness, quality outcomes and customer satisfaction for qualifying plans. The qualifying plans for which the standards are adopted include indemnity health insurance, hospital and medical service plans, closed panel medical and dental plans and health maintenance organizations, and for eligibility of the dependents of officers and employees to participate in such plans. Any indemnity health insurance or hospital and medical service plan designated as a qualifying plan by the department of administration AND APPROVED BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD must be open for enrollment to all permanent full-time state employees, except that any plan established ~~prior to~~ BEFORE June 6, 1977 may be continued as a separate plan. Any closed panel medical or dental plan or health maintenance organization designated as a qualifying plan by the department of administration AND APPROVED BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD must be open for enrollment to all permanent full-time state employees residing within the geographic area or area to be served by the plan or organization. Officers and employees may select coverage under the available options.

C. The department of administration, FOLLOWING APPROVAL BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD, may designate the Arizona health care cost containment system established by title 36, chapter 29 as a qualifying plan for the provision of health and accident coverage to full-time state officers and employees and their dependents. The Arizona health care cost containment system shall not be the exclusive qualifying

plan for health and accident coverage for state officers and employees either on a statewide or regional basis.

D. Except as provided in section 38-652, public monies ~~expended~~ SPENT pursuant to this section each month shall not exceed:

1. ~~Five hundred dollars~~ $500 multiplied by the number of officers and employees who receive individual coverage.

2. ~~One thousand two hundred dollars~~ $1,200 multiplied by the number of married couples if both members of the couple are either officers or employees and each receives individual coverage or family coverage.

3. ~~One thousand two hundred dollars~~ $1,200 multiplied by the number of officers or employees who receive family coverage if the spouses of the officers or employees are not officers or employees.

E. Subsection D of this section:

1. Establishes a total maximum expenditure of public monies pursuant to this section.

2. Does not establish a minimum or maximum expenditure for each individual officer or employee.

F. In order to ensure that an officer or employee does not suffer a financial penalty or receive a financial benefit based on the officer's or employee's age, gender or health status, the department of administration, IN CONSULTATION WITH AND ON APPROVAL BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD, shall consider implementing the following:

1. Requests for proposals for health insurance that specify that the carrier's proposed premiums for each plan be based on the expected age, gender and health status of the entire pool of employees and officers and their family members enrolled in all qualifying plans and not on the age, gender or health status of the individuals expected to enroll in the particular plan for which the premium is proposed.

2. Recommendations from a legislatively established study group on risk adjustments relating to a system for reallocating premium revenues among the contracting qualifying plans to the extent necessary to adjust the revenues received by any carrier to reflect differences between the average age, gender and health status of the enrollees in that carrier's plan or plans and the average age, gender and health status of all enrollees in all qualifying plans.

G. Each officer or employee shall certify on the initial application for family coverage that the officer or employee is not receiving more than the contribution for which eligible pursuant to subsection D of this section. Each officer or employee shall also provide the certification on any change of coverage or marital status.

H. If a qualifying health maintenance organization is not available to an officer or employee within fifty miles of the officer's or employee's residence and the officer or employee is enrolled in a qualifying plan, the officer or employee shall be offered the opportunity to enroll with a health maintenance organization when the option becomes

available. If a health maintenance organization is available within fifty miles and ~~it is determined by~~ the department of administration DETERMINES that there is an insufficient number of medical providers in the organization, the department may provide for a change in enrollment from plans designated by the director when additional medical providers join the organization.

I. Notwithstanding subsection H of this section, officers and employees who enroll in a qualifying plan and reside outside the area of a qualifying health maintenance organization shall be offered the option to enroll with a qualified health maintenance organization offered through their provider under the same premiums as if they lived within the area boundaries of the qualified health maintenance organization, if:

1. All medical services are rendered and received at an office designated by the qualifying health maintenance organization or at a facility referred by the health maintenance organization.

2. All nonemergency or nonurgent travel, ambulatory and other expenses from the residence area of the officer or employee to the designated office of the qualifying health maintenance organization or the facility referred by the health maintenance organization are the responsibility of and at the expense of the officer or employee.

3. All emergency or urgent travel, ambulatory and other expenses from the residence area of the officer or employee to the designated office of the qualifying health maintenance organization or the facility referred by the health maintenance organization are paid pursuant to any agreement between the health maintenance organization and the officer or employee living outside the area of the qualifying health maintenance organization.

J. The department of administration shall allow any school district in this state that meets the requirements of section 15-388, a charter school in this state that meets the requirements of section 15-187.01 or a city, town, county, community college district, special taxing district, authority or public entity organized pursuant to the laws of this state that meets the requirements of section 38-656 to participate in the health and accident coverage prescribed in this section, except that participation is only allowed in a health plan that is offered by the department and that is subject to title 20, chapter 1, article 1. A school district, a charter school, a city, a town, a county, a community college district, a special taxing district, an authority or any public entity organized pursuant to the laws of this state rather than this state shall pay directly to the benefits provider the premium for its employees.

K. The department of administration shall determine the actual administrative and operational costs associated with school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities and public entities organized pursuant to the laws of this state participating in ~~the~~ state health and

accident insurance coverage. These costs shall be allocated to each school district, charter school, city, town, county, community college district, special taxing district, authority and public entity organized pursuant to the laws of this state based on the total number of employees participating in the coverage. This subsection only applies to a health plan that is offered by the department and that is subject to title 20, chapter 1, article 1.

L. Insurance providers contracting with this state shall separately maintain records that delineate claims and other expenses attributable to participation of a school district, charter school, city, town, county, community college district, special taxing district, authority and public entity organized pursuant to the laws of this state in ~~the~~ state health and accident insurance coverage and, by November 1 of each year, shall report to the department of administration the extent to which state costs are impacted by participation of school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities and public entities organized pursuant to the laws of this state in ~~the~~ state health and accident insurance coverage. By December 1 of each year, the director of the department of administration shall submit a report to the president of the senate, ~~and~~ the speaker of the house of representatives AND THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD detailing the information provided to the department by the insurance providers and including any recommendations for possible legislative action.

M. Notwithstanding subsection J of this section, any school district in this state that meets the requirements of section 15-388, a charter school in this state that meets the requirements of section 15-187.01 or a city, town, county, community college district, special taxing district, authority or public entity organized pursuant to the laws of this state that meets the requirements of section 38-656 may apply to the department of administration to participate in the self-insurance program that is provided ~~by~~ PURSUANT TO this section pursuant to rules adopted by the department. A participating entity shall reimburse the department for all premiums and administrative or other insurance costs. The department shall actuarially prescribe the annual premium for each participating entity to reflect the actual cost of each participating entity.

N. Any person that submits a bid to provide health and accident coverage pursuant to this section shall disclose any court or administrative judgments or orders issued against that person within the last ten years before the submittal.

O. SUBJECT TO APPLICABLE STATE AND FEDERAL LAW, THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD SHALL DEVELOP REQUIREMENTS FOR THE SHARING OF ANONYMIZED AND AGGREGATED CLAIM AND TREND DATA WITH EMPLOYERS

THAT PARTICIPATE IN HEALTH BENEFIT PROGRAMS FUNDED BY THE SPECIAL EMPLOYEE HEALTH INSURANCE TRUST FUND ESTABLISHED BY SECTION 38-654.

~~O.~~ P. For the purposes of this section, "dependent" means a spouse under the laws of this state, a child who is under twenty-six years of age or a child who ~~was disabled~~ HAD A DISABILITY before reaching nineteen years of age, who continues to ~~be disabled~~ HAVE A DISABILITY under 42 United States Code section 1382c and for whom the employee had custody before ~~reaching~~ THE CHILD REACHED nineteen years of age.

Sec. 4. Section 38-654, Arizona Revised Statutes, is amended to read:

38-654. Special employee health insurance trust fund; purpose; investment of monies; use of monies; exemption from lapsing; report

A. The special employee health insurance trust fund is established to administer the state employee health insurance benefit plans. The fund shall consist of legislative appropriations, monies collected from the employer and employees for the health insurance benefit plans and investment earnings on monies collected from employees. The fund shall be administered by the director of the department of administration. Monies in the fund that are determined by the legislature to be for administrative expenses of the department of administration, including monies authorized by subsection C, paragraph 4 of this section, are subject to legislative appropriation.

B. On notice from the department of administration, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. There shall be a separate accounting of monies contributed by the employer, monies collected from state employees and investment earnings on monies collected from employees. Monies collected from state employees for health insurance benefit plans shall be ~~expended~~ SPENT before expenditure of monies contributed by the employer.

C. Monies in the fund shall be used by the department of administration for the following purposes for the benefit of officers and employees who participate in a health insurance benefit plan pursuant to this article:

1. To administer a health insurance benefit program for state officers and employees.

2. To pay health insurance premiums, claims costs and related administrative expenses.

3. To apply against future premiums, claims costs and related administrative expenses.

4. To apply the equivalent of not more than $1.50 for each employee for each month to administer applicable federal and state laws relating to health insurance benefit programs and to design, implement and administer improvements to the employee health insurance or benefit program AS

APPROVED BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD ESTABLISHED BY SECTION 38-655.

D. Subsection C of this section does not require that all monies in the special employee health insurance trust fund be used within any one or more fiscal years. Any person who is no longer a state employee or an employee who is no longer a participant in a health insurance plan under contract with the department of administration shall have no claim on monies in the fund.

E. Monies deposited in or credited to the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

~~F. The department of administration shall submit an annual report on the financial status of the special employee insurance trust fund to the governor, the president of the senate, the speaker of the house of representatives, the chairpersons of the house and senate appropriations committees and the joint legislative budget committee staff by July 1. The department shall make the report available to officers and employees who have paid premiums under one of the insurance plans from which monies were received for deposit in the trust account since the inception of the health and accident coverage program or since the department submitted the last report, whichever is later. The report shall include:~~

~~1. The actuarial assumptions and a description of the methodology used to set premiums and reserve balance targets for the health insurance benefit program for the current plan year.~~

~~2. An analysis of the actuarial soundness of the health insurance benefit program for the previous plan year.~~

~~3. An analysis of the actuarial soundness of the health insurance benefit program for the current plan year, based on both year-to-date experience and total expected experience.~~

~~4. A preliminary estimate of the premiums and reserve balance targets for the next plan year, including the actuarial assumptions and a description of the methodology used.~~

~~5. The required and actual performance standards for the prior plan year for the contracted health plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations.~~

~~G.~~ F. The department shall submit a report to the joint legislative budget committee detailing any changes APPROVED BY THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD to the type of benefits offered under the plan and associated costs at least forty-five days before making the change. The report shall include:

1. An estimate of the cost or saving associated with the change.

2. An explanation of why the change was implemented before the next plan year.

Sec. 5. Title 38, chapter 4, article 4, Arizona Revised Statutes, is amended by adding section 38-655, to read:

38-655. Health insurance trust fund oversight board; members; duties; annual report; exemption

A. THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD IS ESTABLISHED CONSISTING OF THE FOLLOWING MEMBERS:

1. THE ASSISTANT DIRECTOR OF THE DEPARTMENT OF ADMINISTRATION, BENEFITS SERVICES DIVISION, WHO SERVES AS CHAIRPERSON OF THE BOARD.

2. THE DIRECTOR OF THE DEPARTMENT OF ADMINISTRATION OR THE DIRECTOR'S DESIGNEE.

3. THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS OR THE DIRECTOR'S DESIGNEE.

4. ONE MEMBER WHO IS APPOINTED BY THE PRESIDENT OF THE SENATE AND ONE MEMBER WHO IS APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, EACH OF WHOM:

(a) SHALL SERVE A TERM OF TWO YEARS OR AT THE PLEASURE OF THE APPOINTING AUTHORITY. A BOARD MEMBER WHO IS APPOINTED PURSUANT TO THIS PARAGRAPH IS ELIGIBLE FOR REAPPOINTMENT.

(b) HAS AT LEAST THREE YEARS OF EXPERIENCE IN THE HEALTH CARE INDUSTRY IN THIS STATE AND WHO IS NOT A REGISTERED LOBBYIST.

B. A PERSON IS NOT ELIGIBLE TO SERVE AS A MEMBER OF THE BOARD DURING THE TERM FOR WHICH THE PERSON HAS BEEN ELECTED OR APPOINTED TO FILL AN OTHERWISE ELECTED POSITION.

C. MEMBERS OF THE BOARD ARE SUBJECT TO THE PROVISIONS OF CHAPTER 3, ARTICLE 8 OF THIS TITLE RELATING TO CONFLICTS OF INTEREST.

D. THE BOARD SHALL MEET AT LEAST TWO TIMES ANNUALLY. MEETINGS MAY BE HELD AT THE CALL OF THE CHAIRPERSON OR A MAJORITY OF THE BOARD MEMBERS. THREE MEMBERS OF THE HEALTH INSURANCE TRUST FUND OVERSIGHT BOARD SHALL CONSTITUTE A QUORUM TO CONDUCT BUSINESS. BOARD MEETINGS MAY BE CONDUCTED VIRTUALLY. BOARD MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION FOR BOARD SERVICE AND ARE NOT ELIGIBLE TO RECEIVE REIMBURSEMENT FOR EXPENSES PURSUANT TO ARTICLE 2 OF THIS CHAPTER.

E. THE BOARD SHALL:

1. APPROVE ALL HEALTH INSURANCE BENEFIT PROGRAMS OFFERED TO STATE OFFICERS AND EMPLOYEES PURSUANT TO SECTION 38-654.

2. APPROVE PREMIUM RATES, COPAYMENTS, DEDUCTIBLES AND COINSURANCE PERCENTAGES AND MAXIMUMS FOR THE PLAN.

3. FOR PLAN YEAR 2028 AND EACH SUBSEQUENT PLAN YEAR, APPROVE ANY REQUESTS FOR PROPOSAL CONTRACT OF MORE THAN $3,000,000 THAT ARE ENTERED INTO BY THE DEPARTMENT OF ADMINISTRATION FOR THE USES SET FORTH IN SECTION 38-654, SUBSECTION C. THE BOARD SHALL MEET TO REVIEW THE DEPARTMENT OF ADMINISTRATION'S CONTRACT WITHIN TEN DAYS AFTER THE REQUEST OF THE DEPARTMENT.

4. CONSULT WITH THE DEPARTMENT OF ADMINISTRATION AS REQUIRED BY THIS ARTICLE AND AT THE REQUEST OF THE DEPARTMENT OF ADMINISTRATION.

5. DEVELOP AND MAINTAIN A STRATEGIC PLAN FOR THE STATE HEALTH PLAN.

6. DESIGN POLICIES THAT SEEK TO, BY PLAN YEAR 2035 AND FOR EACH SUBSEQUENT PLAN YEAR, ACHIEVE:

(a) A PREMIUM COST SHARING OF EIGHTY-FIVE PERCENT TO BE PAID BY THE EMPLOYER AND FIFTEEN PERCENT TO BE PAID BY THE EMPLOYEE FOR MEDICAL PREMIUMS.

(b) A CONSISTENT RESERVE IN THE SPECIAL EMPLOYEE HEALTH INSURANCE TRUST FUND ESTABLISHED BY SECTION 38-654 THAT IS TWICE THE TOTAL AMOUNT OF INCURRED, BUT NOT REPORTED, CLAIMS PAYABLE FROM HEALTH BENEFIT PROGRAMS FUNDED BY THE SPECIAL EMPLOYEE HEALTH INSURANCE TRUST FUND.

(c) OPTIMAL CROSS SUBSIDIZATION OF RETIREES.

F. ON OR BEFORE JULY 1, 2027 AND EACH YEAR THEREAFTER, THE BOARD SHALL APPROVE AND THE DEPARTMENT OF ADMINISTRATION SHALL SUBMIT AN ANNUAL REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, THE CHAIRPERSONS OF THE SENATE AND THE HOUSE OF REPRESENTATIVES APPROPRIATIONS COMMITTEES AND THE JOINT LEGISLATIVE BUDGET COMMITTEE STAFF. THE DEPARTMENT OF ADMINISTRATION SHALL MAKE THE ANNUAL REPORT AVAILABLE TO OFFICERS AND EMPLOYEES WHO HAVE PAID PREMIUMS UNDER ANY OF THE INSURANCE PLANS FROM WHICH MONIES WERE RECEIVED FOR DEPOSIT IN THE SPECIAL EMPLOYEE HEALTH INSURANCE TRUST FUND SINCE THE INCEPTION OF THE STATE HEALTH AND ACCIDENT INSURANCE PLAN OR SINCE THE DEPARTMENT OF ADMINISTRATION SUBMITTED THE MOST RECENT ANNUAL REPORT, WHICHEVER IS LATER. THE ANNUAL REPORT MUST INCLUDE:

1. THE BOARD'S STRATEGIC PLAN FOR THE STATE HEALTH PLAN.

2. THE ANNUAL ACTIVITIES OF THE BOARD.

3. THE ACTUARIAL ASSUMPTIONS AND A DESCRIPTION OF THE METHODOLOGY USED TO SET PREMIUMS AND RESERVE BALANCE TARGETS FOR THE HEALTH INSURANCE BENEFIT PLAN FOR THE CURRENT PLAN YEAR.

4. AN ANALYSIS OF THE ACTUARIAL SOUNDNESS OF THE HEALTH INSURANCE BENEFIT PLAN FOR THE PREVIOUS PLAN YEAR.

5. AN ANALYSIS OF THE ACTUARIAL SOUNDNESS OF THE HEALTH INSURANCE BENEFIT PLAN FOR THE CURRENT PLAN YEAR, BASED ON BOTH YEAR-TO-DATE EXPERIENCE AND TOTAL EXPECTED EXPERIENCE.

6. A PRELIMINARY ESTIMATE OF THE PREMIUMS AND RESERVE BALANCE TARGETS FOR THE NEXT PLAN YEAR, INCLUDING THE ACTUARIAL ASSUMPTIONS AND A DESCRIPTION OF THE METHODOLOGY USED.

7. THE REQUIRED AND ACTUAL PERFORMANCE STANDARDS FOR THE PRIOR PLAN YEAR FOR THE CONTRACTED HEALTH PLANS, INCLUDING INDEMNITY HEALTH INSURANCE, HOSPITAL AND MEDICAL SERVICE PLANS, DENTAL PLANS AND HEALTH MAINTENANCE ORGANIZATIONS.

G. SECTION 41-2955, SUBSECTION D DOES NOT APPLY TO THE BOARD.

Sec. 6. Review of member eligibility information; eligibility redetermination; waiver requests; delayed repeal; definitions

A. The administration shall review information that is provided by the Arizona lottery commission and the department of gaming to identify members of households who have won substantial lottery or gambling winnings, as defined by 7 Code of Federal Regulations section 273.11(r)(2), including online gambling winnings, and incorporate the information into eligibility determinations.

B. The administration shall:

1. Receive and review death records information from the department of health services concerning members and shall adjust system eligibility accordingly.

2. Review information concerning members that indicates a change in circumstances that may affect eligibility, including potential changes in residency as identified by out-of-state enrollment in a state's medicaid program, temporary assistance for needy families program or supplemental nutrition assistance program or by an out-of-state death record.

C. For all eligibility redeterminations for medical assistance under a state plan or a waiver under that state plan scheduled on or after the first day of the first quarter that begins after December 31, 2026, and unless otherwise approved as a waiver by the centers for medicare and medicaid services, the administration shall comply with federal law and regulations, including 42 United States Code section 1396a(e)(14). For the purposes of the redetermination process, the administration shall receive and review information from the department of economic security concerning members that indicates a change in circumstances that may affect eligibility, including changes to unemployment benefits, employment status or wages.

D. To the extent allowed by federal law, the administration may not accept self-attestation of residency without independent verification before enrollment.

E. The administration may not accept eligibility determinations for the system from an exchange established pursuant to 42 United States Code section 18041(c). The administration may accept assessments from an exchange established pursuant to 42 United States Code section 18041(c) but shall independently verify eligibility and make eligibility determinations.

F. If the administration receives reliable information concerning a member that indicates a change in the member's circumstances that may affect eligibility, the administration shall review the member's eligibility.

G. The administration may execute a memorandum of understanding with any other department of this state for information required to be shared pursuant to this section. The administration may contract with one

or more independent vendors to provide additional data or information that may indicate a change in circumstances and affect an individual's eligibility.

H. On or before April 1, 2027, the administration shall submit to the centers for medicare and medicaid services any waiver requests necessary to implement this section.

I. This section is repealed from and after June 30, 2027.

J. For the purposes of this section, "administration" and "member" have the same meanings prescribed in section 36-2901, Arizona Revised Statutes.

Sec. 7. Presumptive eligibility; limits; standards; notification; training; delayed repeal; definition

A. The administration shall request approval from the centers for medicare and medicaid services for a section 1115 waiver to allow the administration to eliminate mandatory hospital presumptive eligibility and restrict presumptive eligibility determinations to children and pregnant women eligibility groups. If approval for the section 1115 waiver is denied, the administration shall resubmit a subsequent request for approval within twelve months after each denial.

B. Unless required by federal law, the administration may not designate itself as a qualified health entity for the purpose of making presumptive eligibility determinations or for any purpose not expressly authorized by state law.

C. When making presumptive eligibility determinations, a qualified hospital shall do all of the following:

1. Notify the administration of each presumptive eligibility determination within five working days after the date the determination is made.

2. Assist individuals who are determined presumptively eligible under the system with completing and submitting a full application for system eligibility.

3. Notify each applicant in writing and on all relevant forms with plain language and large print that if the applicant does not file a full application for system eligibility with the administration before the last day of the following month, presumptive eligibility coverage will end on the last day of the following month.

4. Notify each applicant that if the applicant files a full application for system eligibility with the administration before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application that is filed.

D. The administration shall apply the following standards to establish and ensure that accurate presumptive eligibility determinations are made by each qualified hospital:

1. Whether the qualified hospital submitted to the administration the presumptive eligibility card within five working days after the determination date.

2. Whether a full application for system eligibility was received by the administration before the expiration of the presumptive eligibility period.

3. If a full application was received by the administration, whether the individual was found to be eligible under the system.

E. If the administration determines that a qualified hospital fails to meet any of the standards established under subsection D of this section for any presumptive eligibility determination that the qualified hospital made, the administration shall notify the qualified hospital in writing within five days after the determination. The notice must include:

1. For the first violation, both of the following:

(a) A description of the standard that was not met and an explanation of why it was not met.

(b) Confirmation that a second finding will require that all applicable hospital staff participate in mandatory training by the administration on hospital presumptive eligibility rules.

2. For the second violation, all of the following:

(a) A description of the standard that was not met and an explanation of why it was not met.

(b) Confirmation that all applicable hospital staff will be required to participate in mandatory training by the administration on hospital presumptive eligibility rules, including the date, time and location of the training as determined by the administration.

(c) A description of available appeals procedures by which a qualified hospital may dispute the finding and remove the finding from the qualified hospital's record by providing clear and convincing evidence that the standard was met.

(d) Confirmation that if the qualified hospital subsequently fails to meet any standard for presumptive eligibility for any determination, the qualified hospital will no longer be qualified to make presumptive eligibility determinations under the system.

3. For the third violation, all of the following:

(a) A description of the standard that was not met and an explanation of why it was not met.

(b) A description of available appeals procedures by which a qualified hospital may dispute the finding and remove the finding from the qualified hospital's record by providing clear and convincing evidence that the standard was met.

(c) Confirmation that, effective immediately, the qualified hospital is no longer qualified to make presumptive eligibility determinations under the system.

F. This section is repealed from and after June 30, 2027.

G. For the purposes of this section, "administration" has the same meaning prescribed in section 36-2901, Arizona Revised Statutes.

Sec. 8. Dementia services program; department duties; Alzheimer's disease state plan; posting; reporting requirement; advisory council; delayed repeal; definition

A. The department of health services is designated as the lead agency in this state to address Alzheimer's disease and related forms of dementia.

B. The director of the department of health services shall establish a dementia services program within the department that does all of the following:

1. Facilitates the coordination of programs that relate to Alzheimer's disease and related forms of dementia in all state agencies.

2. Facilitates the coordination, review, publication and implementation of and updates to the Alzheimer's disease state plan developed pursuant to this section.

3. Applies for public health funding and grants related to Alzheimer's disease and related forms of dementia.

4. Incorporates evidence-based brain health strategies into relevant department-led public health programs.

C. The department shall develop an Alzheimer's disease state plan that assesses the current and future impact of Alzheimer's disease and related forms of dementia on this state and that:

1. Assesses and identifies relevant gaps in all of the following:

(a) Existing state services and resources that address the needs of persons living with Alzheimer's disease or a related form of dementia and their caregivers.

(b) The needs of persons who have Alzheimer's disease or a related form of dementia and how their lives are affected throughout the progression of the disease.

(c) This state's public and private health systems, workforce and clinical capacity and capability to provide effective detection, diagnosis and treatment of Alzheimer's disease and related forms of dementia.

(d) This state's public and private nonmedical care and support services for persons living with Alzheimer's disease or a related form of dementia and their caregivers.

2. Provides strategic recommendations with measurable goals for state action to do all of the following for persons living with Alzheimer's disease or a related form of dementia:

(a) Improve access to care, support, diagnostics and treatment.

(b) Improve the quality of dementia care, including crisis response, health care systems, long-term care and in-home care.

(c) Advance risk reduction and early detection awareness and brain health.

(d) Improve caregiver support, care planning and care coordination.

(e) Improve the collection, availability and use of dementia-related data by state agencies.

D. The department shall convene or designate an advisory council or working group to assist in planning, conducting and evaluating stakeholder engagement and state plan implementation, review and updates. Membership of the advisory council or working group shall reflect the diversity of stakeholders identified in subsection E, paragraph 1 of this section.

E. The department shall conduct stakeholder engagement sessions at least once each calendar year to solicit input on the state plan. The department shall:

1. Seek feedback from and collaborate with persons who have Alzheimer's disease or a related form of dementia, direct caregivers and public, private and nonprofit organizations focused on Alzheimer's care services, research, advocacy, health services and caregiver support.

2. At least thirty days before each engagement session, provide public notice of the session, including the date, time, location or virtual access information, a summary agenda and instructions for submitting written comments.

3. Ensure meaningful participation by stakeholders statewide, including rural and underserved communities, and provide reasonable accommodations and language access.

4. Accept written comments for at least fourteen days following each engagement session.

F. On or before June 30, 2027, the department shall update and submit the state plan to the governor, the president of the senate and the speaker of the house of representatives and shall provide a copy to the secretary of state. The department shall publish the plan on the department's public website.

G. This section is repealed from and after June 30, 2027.

H. For the purposes of this section, "caregiver" means an unpaid person who provides regular assistance in activities of daily living for a person living with Alzheimer's disease or a related form of dementia.

Sec. 9. AHCCCS; urban Indian organizations; traditional health services; pilot coverage; administrative action; delayed repeal; definitions

A. Subject to a section 1115 waiver approval by the centers for medicare and medicaid services, for fiscal years 2026-2027, 2027-2028 and 2028-2029, the Arizona health care cost containment system and its contractors shall provide pilot coverage for traditional healing services at urban Indian health organizations if both of the following apply:

1. The member qualifies for services through the Indian health service or a tribal facility pursuant to the conditions of participation outlined in 42 Code of Federal Regulations section 136.12.

2. The traditional healing services are delivered by or through an urban Indian organization.

B. The director of the Arizona health care cost containment system may take any administrative action necessary to implement this section.

C. This section is repealed from and after December 31, 2029.

D. For the purposes of this section:

1. "Contractor" has the same meaning prescribed in section 36-2901, Arizona Revised Statutes.

2. "Member" has the same meaning prescribed in section 36-2901, Arizona Revised Statutes.

3. "Urban Indian organization" means an urban Indian organization in this state that receives Indian health services funding pursuant to 25 United States Code chapter 18.

Sec. 10. ALTCS; county contributions; fiscal year 2026-2027

A. Notwithstanding section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2026-2027 are as follows:

1.	Apache	$ 792,400
2.	Cochise	$ 8,055,900
3.	Coconino	$ 2,378,900
4.	Gila	$ 3,365,400
5.	Graham	$ 2,320,400
6.	Greenlee	$ 138,200
7.	La Paz	$ 756,100
8.	Maricopa	$298,895,000
9.	Mohave	$ 12,022,500
10.	Navajo	$ 3,279,800
11.	Pima	$ 68,282,000
12.	Pinal	$ 19,662,800
13.	Santa Cruz	$ 3,204,100
14.	Yavapai	$ 8,793,400
15.	Yuma	$ 13,867,000

B. If the overall cost for the Arizona long-term care system exceeds the amount specified in the general appropriations act for fiscal year 2026-2027, the state treasurer shall collect from the counties the difference between the amount specified in subsection A of this section and the counties' share of the state's actual contribution. The counties' share of the state's contribution must comply with any federal maintenance of effort requirements. The director of the Arizona health care cost containment system administration shall notify the state treasurer of the counties' share of the state's contribution and report the amount to the director of the joint legislative budget committee. The state treasurer shall withhold from any other monies payable to a county from whatever state funding source is available an amount necessary to fulfill that county's requirement specified in this subsection. The state treasurer

may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes. The state treasurer shall deposit the amounts withheld pursuant to this subsection and amounts paid pursuant to subsection A of this section in the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

Sec. 11. AHCCCS; disproportionate share payments; fiscal year 2026-2027

A. Disproportionate share payments for fiscal year 2026-2027 made pursuant to section 36-2903.01, subsection O, Arizona Revised Statutes, include:

1. $28,474,900 for the Arizona state hospital. The Arizona state hospital shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the Arizona health care cost containment system administration on or before March 31, 2027. The administration shall assist the Arizona state hospital in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal financial participation based on the amount certified by the Arizona state hospital, the administration shall deposit the entire amount of federal financial participation in the state general fund. If the certification provided is for an amount less than $28,474,900, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall deposit the entire amount of federal financial participation in the state general fund. The certified public expense form provided by the Arizona state hospital must contain both the total amount of qualifying disproportionate share hospital expenditures and the amount limited by section 1923(g) of the social security act.

2. $884,800 for private qualifying disproportionate share hospitals. The Arizona health care cost containment system administration shall make payments to hospitals consistent with this appropriation and the terms of the state plan, but payments are limited to those hospitals that either:

(a) Meet the mandatory definition of disproportionate share qualifying hospitals under section 1923 of the social security act.

(b) Are located in Yuma county and contain at least three hundred beds.

B. After the distributions made pursuant to subsection A of this section, the allocations of disproportionate share hospital payments made pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, shall be made available in the following order to qualifying private hospitals that are:

1. Located in a county with a population of less than four hundred thousand persons.

2. Located in a county with a population of at least four hundred thousand persons but less than nine hundred thousand persons.

3. Located in a county with a population of at least nine hundred thousand persons.

Sec. 12. AHCCCS transfer; counties; federal monies; fiscal year 2026-2027

On or before December 31, 2027, notwithstanding any other law, for fiscal year 2026-2027, the Arizona health care cost containment system administration shall transfer to the counties the portion, if any, as may be necessary to comply with section 10201(c)(6) of the patient protection and affordable care act (P.L. 111-148), regarding the counties' proportional share of this state's contribution.

Sec. 13. County acute care contributions; fiscal year 2026-2027; intent

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2026-2027 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

1.	Apache	$ 268,800
2.	Cochise	$ 2,214,800
3.	Coconino	$ 742,900
4.	Gila	$ 1,413,200
5.	Graham	$ 536,200
6.	Greenlee	$ 190,700
7.	La Paz	$ 212,100
8.	Maricopa	$14,417,300
9.	Mohave	$ 1,237,700
10.	Navajo	$ 310,800
11.	Pima	$14,951,800
12.	Pinal	$ 2,715,600
13.	Santa Cruz	$ 482,800
14.	Yavapai	$ 1,427,800
15.	Yuma	$ 1,325,100

B. If a county does not provide funding as specified in subsection A of this section, the state treasurer shall subtract the amount owed by the county to the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes, from any payments required to be made by the state treasurer to that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant to section 44-1201, Arizona Revised Statutes, retroactive to the first day the funding was due. If the monies the state treasurer withholds are insufficient to meet that county's funding requirements as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The

state treasurer may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total amount determined pursuant to subsection A of this section shall be made to the state treasurer on or before the fifth day of each month. On request from the director of the Arizona health care cost containment system administration, the state treasurer shall require that up to three months' payments be made in advance, if necessary.

D. The state treasurer shall deposit the amounts paid pursuant to subsection C of this section and amounts withheld pursuant to subsection B of this section in the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

E. If payments made pursuant to subsection C of this section exceed the amount required to meet the costs incurred by the Arizona health care cost containment system for the hospitalization and medical care of those persons defined as an eligible person pursuant to section 36-2901, paragraph 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of the Arizona health care cost containment system administration may instruct the state treasurer either to reduce remaining payments to be paid pursuant to this section by a specified amount or to provide to the counties specified amounts from the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

F. The legislature intends that the Maricopa county contribution pursuant to subsection A of this section be reduced in each subsequent year according to the changes in the GDP price deflator. For the purposes of this subsection, "GDP price deflator" has the same meaning prescribed in section 41-563, Arizona Revised Statutes.

Sec. 14. AHCCCS; mental health medication utilization; report; definition

A. Not later than January 31, 2027, the Arizona health care cost containment system administration shall prepare and issue a report to the governor, the chairpersons of the house of representatives and senate health and human services committees, or their successor committees, the director of the joint legislative budget committee and the director of the governor's office of strategic planning and budgeting that includes information about the costs and aggregate spending on and aggregate utilization of mental health medications during contract year 2024-2025. The administration shall provide a copy of the report to the secretary of state.

B. The report required by subsection A of this section shall include the annual aggregate gross amount spent for each mental health medication class and the annual aggregate net amount spent by this state

for each mental health medication class after rebates without disclosing any information about manufacturer-negotiated supplemental rebate agreements for any specific drug. The report shall also include the average annual cost by class for generic and nongeneric mental health medications. Without disclosing any information about manufacturer-negotiated supplemental rebate agreements that could compromise the competitive or proprietary nature of these agreements, for antipsychotic and antidepressant medications, the report shall include the total number of prior authorizations submitted for nonpreferred antipsychotic and nonpreferred antidepressant medications, the percentage of prior authorization approvals and denials, the generic antipsychotic and generic antidepressant medication utilization percentages and the total amount of antipsychotic and antidepressant medication claims.

C. For purposes of this section, "mental health medication" means the following medications:

1. Antipsychotics.
2. Antidepressants.
3. Anxiolytics.
4. Stimulants.
5. Sedative hypnotics.

Sec. 15. Proposition 204 administration; exclusion; county expenditure limitations

County contributions for the administrative costs of implementing sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made pursuant to section 11-292, subsection O, Arizona Revised Statutes, are excluded from the county expenditure limitations.

Sec. 16. Competency restoration; exclusion; county expenditure limitations

County contributions made pursuant to section 13-4512, Arizona Revised Statutes, are excluded from the county expenditure limitations.

Sec. 17. Opioid settlement funds agreement; expenditure limitation; penalty reduction; fiscal year 2026-2027

Notwithstanding section 41-1279.07, Arizona Revised Statutes, for fiscal year 2026-2027, if a county, city or town exceeds its expenditure limitation prescribed in article IX, section 20, Constitution of Arizona, due to spending monies received from the one Arizona distribution of opioid settlement funds agreement, the penalty shall be reduced by the amount of the one Arizona distribution of opioid settlement funds agreement monies spent and may not be less than $0.

Sec. 18. AHCCCS; risk contingency rate setting

Notwithstanding any other law, for the contract year beginning October 1, 2026 and ending September 30, 2027, the Arizona health care cost containment system administration may continue the risk contingency rate setting for all managed care organizations and the funding for all

managed care organizations administrative funding levels that were imposed for the contract year beginning October 1, 2010 and ending September 30, 2011.

Sec. 19. Rulemaking exemption

Notwithstanding any other law, for the purposes of adopting policies and rules related to service frequency or hour limitations for covered services pursuant to title 36, chapter 29, Arizona Revised Statutes, the Arizona health care cost containment system administration is exempt from the requirements of title 41, chapter 6, Arizona Revised Statutes, in fiscal year 2026-2027, except that the Arizona health care cost containment system administration shall provide notice and at least thirty days for public comment before implementing policies and rules related to service frequency or hour limitations.

Sec. 20. Rulemaking exemption; retroactivity

A. Notwithstanding any other law, for the purposes of implementing the hospital assessment pursuant to sections 36-2907.08 and 36-2999.72, Arizona Revised Statutes, the Arizona health care cost containment system administration is exempt from the requirements of title 41, chapter 6, Arizona Revised Statutes, in fiscal year 2026-2027.

B. This section applies retroactively to from and after June 30, 2026.

Sec. 21. Legislative intent; implementation of program

The legislature intends that for fiscal year 2026-2027 the Arizona health care cost containment system administration implement a program within the available appropriation.

Sec. 22. Applicability

Section 36-798.51, Arizona Revised Statutes, as amended by this act, applies to contracts entered into or renewed from and after December 31, 2026.