



**Written Testimony**

**of**

**Christie Herrera**

**Director, Health and Human Services Task Force  
American Legislative Exchange Council**

**on**

**Arizona House Concurrent Resolution 2014**

**to the**

**House Health and Human Services Committee**

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## **Introduction**

Good morning Chairwoman Barto, Vice Chairman Court, and members of the Committee:

My name is Christie Herrera and I am the director of the Health and Human Services Task Force at the American Legislative Exchange Council, or “ALEC.” ALEC is the nation’s largest, nonpartisan membership association, with approximately 2,000 legislator members from all 50 states and 78 members of Congress. Right here in Arizona, we have 37 ALEC members in the House and Senate. Since 2005, 22 states have enacted model legislation drafted by ALEC’s Health and Human Services Task Force.

## **ALEC Commends HCR 2014**

I submit this statement to commend House Concurrent Resolution 2014, which would protect the rights of Arizonans to make their own health care choices.

HCR 2014 is modeled after ALEC’s model legislation, the *Freedom of Choice in Health Care Act*. Five other states—Minnesota, New Mexico, North Dakota, Wisconsin, and Wyoming—have introduced legislation similar to HCR 2014.

## **HCR 2014 Will Preserve Access to Health Coverage Choices**

It’s no surprise that the biggest issue facing Arizona is access to affordable, meaningful health coverage. More than 1.2 million Arizonans, or nearly one in five, are uninsured. This statistic dwarfs the national average, and ranks Arizona as the state with the sixth-highest percentage of uninsured citizens.<sup>1</sup>

But like most states, Arizona’s uninsured population is very diverse. A growing number of the uninsured lack access to employer-sponsored coverage; are eligible, but not enrolled, in Medicaid or SCHIP; or are denied coverage due to costly chronic diseases. Others don’t choose to buy insurance because it isn’t a good “deal” for them. Nationally, more than eight million Americans have incomes above 300% of the federal poverty level—that’s a family of four earning \$61,950—but still don’t have coverage.

Despite Arizona’s diverse uninsured population, some lawmakers seek to solve this problem with a coercive, one-size-fits-all universal coverage system that limits health choices. What’s worse, most universal coverage schemes aren’t “universal” unless they prevent citizens from obtaining private coverage, or from choosing coverage options not allowed by the government.

By prohibiting a government-run, universal health system—in which residents would be forced to enroll—HCR 2014 will help Arizona’s uninsured maintain access to a broad and vibrant array of private sector health plan choices. Arizona’s diverse uninsured population deserves a diverse set of solutions.

## **HCR 2014 Will Secure Access to Health Services and Protect the Doctor-Patient Relationship**

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<sup>1</sup> Henry J. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population, States (2006-07), U.S. (2007),” [www.statehealthfacts.org](http://www.statehealthfacts.org).

As in other sectors of our economy, when consumers control the dollars, they make the decisions. To this end, HCR 2014 will block legislation that restricts freedom of choice of a private health plan, and it will also block legislation that interferes with a person's right to pay directly for lawful medical services. These provisions will not only preserve the rights of individuals to make their own health care choices, but they will also allow patients to maintain access to health services.

HCR 2014 is critical in ensuring that Arizonans retain the right to choose their own private health plan. That's because some lawmakers want to enact legislation that would require every Arizonan to enroll in a government-run, government-funded health care plan with a rich benefits package and weak cost-sharing requirements. The resulting overutilization of health services—and skyrocketing spending—will likely force this single-payer scheme to ration care as a cost-containment measure.

Most countries that provide universal health coverage deny critical procedures to patients who need them. Britain's National Health Service has reported that, at any given time, nearly 900,000 Britons are waiting for admission to National Health Service hospitals, and shortages force the cancellation of more than 50,000 operations each year. In Sweden, the wait for heart surgery can be as long as 25 weeks, and the average wait for hip replacement surgery is more than a year. Many of these individuals suffer chronic pain, and some will probably die awaiting treatment.<sup>2</sup>

By blocking an onerous universal coverage scheme, HCR 2014 will prevent Arizonans from being enrolled in a single-payer health system that will simultaneously pay for everyone's health care and limit access to it. After all, access to a waiting list is not access to health care.

HCR 2014 also protects the doctor-patient relationship by ensuring a person's right to pay directly for lawful medical services. Single-payer systems, like in Canada, make it illegal for citizens to go outside the government's health care plan and contract for their own medical services. Cost overruns require most single-payer plans to restrict patient choices, and instead mandate an "evidence-based" treatment schedule that standardizes care and requires provider compliance with government medical decisions.

The problem with government-dictated, "evidence-based" medical care is that no two patients are alike. In other words, guidelines can tell doctors what is best for patients overall, but those population-based recommendations are often inappropriate for individual patients. Health care is a very personal matter—and as such, doctors should decide the best course of medical treatment. Similarly, patients—not government officials—should decide which doctor to see, what treatments to get, and whether or not to get a second or third opinion.<sup>3</sup>

Simply put, when governments—rather than consumers—pay the bill, politically-motivated and budget-conscious bureaucrats decide which drugs, tests, and procedures patients can access. If

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<sup>2</sup> Michael Tanner and Michael Cannon, "Universal Healthcare's Dirty Little Secrets," *Los Angeles Times*, April 5, 2007.

<sup>3</sup> For more information about evidence-based medicine, see: Twila Brase, "Evidence-Based Medicine: Rationing Care, Hurting Patients," *ALEC State Factor*, December 2008.

HCR 2014 is enacted, the right of people to make their own health care choices would be guaranteed by the Arizona Constitution.

### **HCR 2014 Will Save State Dollars from Costly Universal Coverage**

By blocking costly universal coverage proposals, HCR 2014 will save Arizonans from crippling health-related tax hikes and budget cuts.

In particular, Arizona policymakers should heed the cautionary tale of Wisconsin, which in 2007 proposed—and rejected—a single-payer health plan for its citizens.<sup>4</sup> The Wisconsin plan would have required all citizens to drop their private health coverage and instead enroll in a state-administered plan with comprehensive benefits and capped out-of-pocket expenses.

In order to pay for the Wisconsin single-payer plan, all employers would have been required to pay the state between nine and 12 percent of Social Security wages, or about \$340 per month, per worker. Similarly, individuals would have been required to pay the state four percent of Social Security wages, or about \$140 per month. Self-employed persons, and persons with income but no wages—like retirees—would have been required to pay the state 10 percent of their income.

Unsurprisingly, the Wisconsin single-payer plan would have bankrupted that state and resulted in massive tax increases. According to the Tax Foundation<sup>5</sup>:

- Financing the plan would have meant a \$15.2 billion dollar tax increase—the largest tax increase ever enacted by any state.
- At the time, Wisconsin’s tax burden was the seventh-highest in the country. The 14.5 percent payroll tax would have bumped Wisconsin to number one—bringing the state tax burden to 20 percent of income.
- Enacting the plan would have represented the first time any state has voted to double its tax collections in a single year.
- Enacting the plan would have represented the first time any state has passed a tax increase equivalent to 50 percent of general revenues.
- Enacting the plan would have represented the first time any state has passed a tax increase equal to six percent of its GDP—more than 13 times bigger than any state other state tax increase, ever.
- Weak cost-sharing and a rich benefits package would have made the plan more expensive every year—and the plan would have comprised nearly 40 percent of Wisconsin’s budget in the first year alone.

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<sup>4</sup> For more information on the Wisconsin single-payer plan, visit <http://www.healthywisconsin.net/>.

<sup>5</sup> Curtis Dubay, “Things We Thought We’d Never See, But Thanks to the Wisconsin Senate . . .,” Tax Foundation Tax Policy Blog, June 28, 2007.

With a budget deficit projected to be as high as \$3.3 billion,<sup>6</sup> Arizona simply can not afford the high taxes and spending that come with any single-payer health plan. HCR 2014 will protect Arizona's taxpayers from costly, "free"-in-name-only universal coverage.

### **HCR 2014 Will Guard Against Intrusive Mandates That Don't Work**

HCR 2014 would block legislation that imposes costly, bureaucratic penalties for choosing to obtain or decline health coverage. This provision strikes at the heart of individual and employer mandates—implemented in Massachusetts and elsewhere—that penalize individuals and businesses for failing to purchase health insurance.

The Massachusetts example<sup>7</sup> is particularly instructive for Arizona and other states facing onerous individual and employer mandates. As of July 1, 2007, every Massachusetts resident was required to have health insurance—either through their employers, through Medicaid/Medicare, or by purchasing it on the individual market. Every Massachusetts taxpayer must indicate on his state income tax return that he, and his dependents, had health insurance during the previous year, with no lapse longer than 63 days. Failure to comply results in a penalty equal to 50% of the lowest-cost insurance policy available for each month without coverage, or about \$912 per year.

Similarly, the Massachusetts mandate requires employers with more than 11 workers to pay a \$295 "fair share" contribution to the state if they do not make a contribution to their workers' health insurance that is "fair and reasonable" (which is also determined by the state). Businesses that do not comply face a "free rider surcharge" if Massachusetts pays more than \$50,000 for care provided to that company's employees.

Two years into the mandate, Massachusetts still hasn't achieved 100% coverage—in fact, the Bay State only insured about half of its 600,000 uninsured residents. Many of the uninsured were exempt from the mandate because coverage was too expensive. Over half of those who did get insurance got fully- or partially-subsidized coverage, courtesy of Massachusetts taxpayers.

Why has the Massachusetts mandate been proven ineffective? Primarily, it's because compliance is futile. For example, mandating health insurance is often compared to mandating car insurance. But states that mandate car insurance typically still have 15 percent of their drivers uninsured—the same percentage as states that don't mandate car insurance. Similarly, in 1974, Hawaii became the first state that required employers to provide health insurance for their workers. More than 30 years later, Hawaii's uninsured rate still hovers at 10 percent. Many Hawaiian employers escaped the mandate by shifting work to exempt part-time employees.

Enforcement issues also abound. Using state income tax filings for enforcement will make it hard to track down the indigent, the elderly, immigrants, the homeless, the mentally-ill, (and even some state legislators) who don't file state income tax returns. And the weak penalties associated with a Massachusetts-style mandate are often cheaper than purchasing coverage. Last April, PBS profiled one Massachusetts resident, a \$40,000-a-year teacher who said, "I don't have

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<sup>6</sup> Howard Fischer, "Calif. tax rejection weighed in AZ," Arizona Daily Star, May 22, 2009.

<sup>7</sup> For more information on the Massachusetts health plan, see: David A. Hyman, "The Massachusetts Health Plan: The Good, Bad, and the Ugly," Cato Institute Policy Analysis No. 595, June 28, 2007.

a problem with mandating that everyone be covered. I do have a problem with mandating that people be covered by products that are unaffordable.” The cheapest plan he could buy cost \$3,500 per year; instead, he just chose to pay the cheaper penalty.<sup>8</sup>

Simply put, HCR 2014 would protect against intrusive individual and employer mandates that just don’t work.

### **HCR 2014 and Compatible Reforms**

Just as HCR 2014 will prevent a coercive, one-size-fits-all universal coverage system, Arizona’s legislators must work on a diverse, targeted set of policy solutions to cover the uninsured. Some reforms that will advance this goal, along with HCR 2014, are:

#### *Allowing Consumers to Purchase Health Insurance Across State Lines*

Increasing numbers of Arizonans uninsured don’t choose to purchase coverage because it just isn’t a good deal for them. Allowing these “voluntarily uninsured” to purchase health insurance in other states—as they do books, clothes, cars, and other products—will empower uninsured Arizonans to access more health plans at lower prices, while expanding coverage choices for those who are already insured. This ALEC model legislation—the *Health Care Choice Act for States*—will also allow Arizonans who want more extensive benefits to “top up” for richer coverage in other states.

In addition to bringing greater choices and access to health insurance, this policy will also allow Arizona to benefit from innovative plans in other states. Cross-border purchasing of health insurance will cause pressure to create a more competitive Arizona health insurance market. It will bring about quicker access to innovative plans because insurers would face fewer “barriers to entry” into Arizona. In other words, Arizona could benefit from new ideas in other states—while maintaining core consumer and licensing protections important to Arizonans.

#### *Extending Tax Breaks to Individuals, Businesses, and Insurers Who Purchase HSAs*

Health Savings Accounts (HSAs) are becoming an important tool to cover the uninsured. Since its inception in 2003, eight million Americans own an HSA—which is a tax-free medical savings account coupled with a high-deductible health policy. Nearly 150,000 Arizonans, or about five percent of those with private insurance, own an HSA.<sup>9</sup>

Critics of HSAs claim that this consumer-driven insurance tool is primarily for the young and healthy. However, nearly half of HSA owners are over the age of 40, and one in four HSA owners is aged 50 or older.<sup>10</sup> A large health insurance broker reports that, of its customers, 41 percent of HSA owners were previously uninsured, and nearly half of HSA plan purchasers have incomes of \$50,000 or less.<sup>11</sup> And roughly the same percentage of individuals with HSA coverage consider themselves to be in “fair/poor health” as those with non-HSA coverage—

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<sup>8</sup> Susan Dentzer, “Mass. Health Care Plan Praised, But Struggles with Cost,” *The Online NewsHour*, April 28, 2008.

<sup>9</sup> AHIP Center for Policy and Research, *January 2009 Census Shows 8 Million People Covered by HSA/High-Deductible Health Plans*, May 2009.

<sup>10</sup> *Ibid.*

<sup>11</sup> Ehealthinsurance.com, *Health Savings Accounts: January 2005-December 2005*, May 10, 2006.

meaning that patients with chronic illnesses are also choosing high-deductible plans.<sup>12</sup> In fact, the BlueCross BlueShield Association reports that HSA owners are offered more wellness incentives, are more likely to use preventive care, and typically do not forgo needed care because of costs.<sup>13</sup>

A new ALEC model—the *Affordable Health Insurance Act*—is modeled after a successful Georgia reform that increases access to HSAs. To make insurance more affordable, the bill eliminates all state and local “sales taxes,” or premium taxes, on HSA-eligible plans; in cents small businesses to offer insurance by granting them a \$250 tax credit for each employee enrolled in an HSA eligible plan; and gives individual insurance buyers an income tax deduction for the premium associated with the purchase of an HSA-eligible plan.

### **Conclusion**

With hard economic times and tightening state budgets, Arizona simply cannot afford to limit access to health insurance for its uninsured families. That’s why I thank you, Chairwoman Barto, for holding this hearing and for the opportunity to testify on House Concurrent Resolution 2014—common-sense legislation that will preserve freedom of choice for health care consumers, and ensure that patients in need have the widest possible variety of medical options. We look forward to working with Arizona in the weeks and months ahead to develop this proposal. I would be pleased to answer any questions you might have at (202) 742-8505 or [christie@alec.org](mailto:christie@alec.org).

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<sup>12</sup> America’s Health Insurance Plans, *HSAs and Account-Based Plans: An Overview of Preliminary Research*, June 2006.

<sup>13</sup> BlueCross BlueShield Association, “Health Plan Initiatives, Trends and Research in Consumer-Driven Care,” National Consumer Driven Health Summit, October 20, 2008.