



Achieving Universal Health Insurance While Improving the Economy: A Reform Proposal for Oregon

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Introduction

In the United States, most health insurance coverage is obtained either through employment or through a government program. Few of us buy insurance privately or pay for our health care out of pocket. This approach has distanced the consumer from health expenditure decisions. As I have argued elsewhere, comprehensive, low-deductible, low-co-payment health insurance leads to over-utilization and inflation of unit costs and total costs of health care.¹ An argument easily can be made that the problem with health care is not too little insurance, but rather too much insurance (see Appendix). Indeed, the distancing of the consumer from spending decisions has been responsible for about half of the real per capita growth in US health care spending between 1950 and 1990, according to a recent MIT study.² Using the employer as the conduit for over-insurance also has caused employment and health insurance policy to become intertwined, causing losses in productivity due to reduced labor mobility and the use of inefficient staffing structures.

In this paper, we outline a simple reform of health insurance policy that will lower the aggregate cost of care and boost economic productivity. It is modeled after the Swiss health insurance reforms of 1996.³ In contrast to other reforms, the one proposed here could be implemented rapidly with little disruption to existing institutions. It leverages the existing insurance and provider industries, eliminates wasteful and dysfunctional micromanagement of the care delivery system and gets the employer out of the insurance business. It also reduces dramatically the role of government. Government's current, detailed regulatory and delivery system involvement could be dismantled. Government's role would be limited to the tasks of defining and enforcing a single, mandatory Basic Plan and developing a means of providing premium assistance to the truly needy.

The Reform Proposal

The reform proposal offered here is simple. Employers no longer would have the responsibility of finding and paying for health insurance coverage for their employees. Instead, all Oregon individuals or households would be required to obtain a basic health

insurance policy each year. This policy would be offered by all insurance companies in the marketplace and would have identical coverage features. The cost of the premiums for the plan would enjoy the same tax-deductible treatment employer-paid premiums enjoy today. In addition, if desired, the Basic Plan could be integrated with a Health Savings Account (HSA) to provide a vehicle to save for payment of routine procedures while still giving the consumer the incentive to be aggressively price-conscious.⁴

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This so-called Basic Plan would incorporate an annual deductible and co-insurance, but insurers could offer a prescribed range of deductible and co-insurance levels. All participating insurers would have to accept all interested consumers regardless of medical history. The insurance companies could rate their policies only by age and sex of the applicant, and explicit voluntary risk-taking such as smoking, extreme sports, etc. The insurers could compete by charging whatever premium they wished for their Basic Plans. Payment for the Basic Plan would be the responsibility of the consumer, with government providing assistance or tax credits to households on a sliding scale below a certain income threshold.

The Rationale and Risks of Mandated Coverage

Mandated coverage as proposed in this paper is, on its surface, contrary to free market and individual liberty principles. Under these principles, the consumer should be free to not obtain health insurance coverage, and insurers should be free to select whom they will insure, and what they will charge, on the basis of the risks posed by individual insureds. This position has been espoused to some degree recently by Michael Tanner of the Cato Institute, among



others.⁵

The economic rationale for mandated coverage here is the same as it is in automobile liability insurance: An individual's decision to not obtain coverage (in both cases) imposes uncontrollable risks on others. In economics, such cross-person impacts are called “externalities,” and it is well established in economic theory that the existence of such externalities violates the assumptions of competitive market theory. The existence of externalities requires market intervention for market efficiency to be restored.

In the case of automobile insurance, the risk of an accident involving an uninsured person either imposes additional risks on the innocent covered driver or requires that the latter obtain supplementary coverage for uninsured motorists. Mandated coverage, even if enforced imperfectly, reduces the burden imposed on one person by the missteps of others. It resolves the externality.

In the case of health insurance, there are two analogous externality problems. First, an individual who chooses not to obtain health insurance coverage nonetheless will be provided with health care services at emergency rooms, for example, and/or may decide not to pay bills for services received. Significant cross-subsidization occurs in hospital billing wherein the insured person pays a larger average fee in order to compensate the provider for costs that go unpaid by others. Theoretically, the solution to such externality problems might be to not offer care to such an individual or to require prior payment or a retainer for prospective procedures. As an empirical matter, neither method of controlling the externality has proved fully practical or legal in our society, even when the individual seeking care is an illegal resident.

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The second externality problem is more important. This problem relates to the fact that incentives to overspend exist in a comprehensive coverage system, with the result that unit costs are driven up for all consumers of health care services. To draw a homely analogy, imagine that ten friends go out to dinner and agree in advance to share the costs of dinner equally. Every person at the dinner now has an incentive to overeat since, from the individual's perspective, the cost of overeating is only one-tenth of the cost of the extra food. However, when the total bill arrives, it reveals that all diners have overeaten and overspent and, as a group, the entire party is less well off. Our current system of comprehensive health care insurance works in a similar way: With low deductibles and co-payments, the cost of

over-consuming health care appears low to an individual; but when all insureds respond to the pricing in the same way, total spending is higher and premiums must be elevated to recover the cost of the induced over-utilization. As I pointed out in an earlier paper on health care spending, the result of “too much insurance” is that unit costs and total costs are inflated by the price illusion created by the insurance product (see Appendix).

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The Basic Plan mandate proposed here, therefore, will improve, rather than degrade, the efficient operation of insurance markets. Insurers remain free to compete on price and to rate individuals by age, sex and voluntary risky behaviors. However, other health risks, including both revealed and unrevealed pre-existing conditions, in essence would be pooled under an insurance mandate. But pooling is precisely the essence of insurance: It recognizes that there is no economic efficiency gained by differentially pricing individuals who are unable to reverse, *ex post*, draws of unlucky health events.⁶ Thus, to the extent that mandated coverage resolves externalities, market efficiency and individual liberty are enhanced, not degraded.

The risk to the mandated coverage approach, of course, is that the Basic Plan coverage definition will be expanded over time to include all risks, or that the population receiving assistance in the payment of their premium would be unreasonably broadened. In the details of the proposal below, the former is dealt with by limiting Basic Plan coverage to types of health care events that are readily defined using objective, statistical measures. In addition, however, individual insureds will form a large and skeptical lobby that will resist the expansion of coverage and attendant premiums. Making the consumer, rather than the employer, the formal payer of the premiums will shatter the current price illusion that expanded coverage is costless. *Nevertheless, any mandated minimum coverage plan must be crafted in such a way that it remains limited in scope and coverage and does not degenerate to a universal, comprehensive insurance plan that will get us right back to where we started (or worse).*

In the case of the risk of overly generous expansion of premium assistance to the needy, other solutions will have to be applied. In contrast to the current policy context, however, with virtually total lack of consumer discipline, exploding burdens of Medicare and Medicaid, massive hidden cross-subsidies, and micro-management of the care delivery environment, this problem seems trivial.

The Effects on Health Care

The efficiency benefits to the health insurance marketplace flow from the Basic Plan's specific features:

First, the Basic Plan would cover only types of medical conditions and procedures that have risk features that make the use of an insurance mechanism cost effective to the consumer. Coverage of routine conditions do not make good candidates for insurance. Direct payment by the patient for routine conditions is more cost effective, because insurance company overhead adds to the cost and premiums must reflect these costs. It is estimated that the administrative overhead of an insurance system adds about 25 percent on top of the underlying cost of care.⁷ Insurance coverage is most cost effective when it is reserved for unlikely, but potentially costly, events. As a result, catastrophic care insurance coverage costs much less than comprehensive care coverage.⁸

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Second, defining the Basic Plan coverage limitations in the manner described above allows for objective, statistical restrictions on what is, and what is not, covered under the Basic Plan. This will aid in keeping the coverage of the Basic Plan from ballooning to comprehensive coverage of events that do not benefit from an insurance model of pricing.⁹ By having mandatory deductible and co-insurance, and by limiting the types of conditions and procedures covered, the Basic Plan premium is kept very low while protecting consumers against the ruinous cost and consequences of serious conditions. The presence of an annual deductible and coverage restrictions encourage consumers to shop carefully for the most cost effective routine care.

Third, consumers would be able to choose either fee for service or managed care providers. The former gives the consumer the ability to seek any provider while the latter may be able to provide a more attractive premium through its integration of insurance and care provision. In any case, however, the consumer will have an incentive to seek cost-effective providers because of the deductible and co-insurance features of the Basic Plan.

Fourth, the requirement that insurers accept all applicants for the same policy at its posted rate eliminates the risk that a consumer will be unable to obtain insurance because of a pre-existing medical condition. This is a common cause of some of the most devastating lapses in the current system. It is also one of the most difficult risk management challenges for insurers and the cause for some of the most heavy-handed insurance regulation and intrusive inquiries into individual medical histories. Under this proposal, these issues are moot because all insurers serve the same risk pool.

Fifth, allowing the consumer to choose among a consistent range of more or less generous deductible and co-insurance options allows the consumer to tailor his plan choice to his particular economic and health circumstances. Having mandatory co-insurance and deductible features, moreover, helps control for overuse of health insurance coverage. The tendency for insureds to over-consume health care is the so-called “price illusion” or “incentive effect” of insurance and is one of the main causes of spiraling health care costs. A recent study found that consumers who have to pay the entirety of the cost of an outpatient procedure impose only half the cost on the health care system of those who do not have to pay anything on the margin.¹⁰

Sixth, by providing assistance to the lowest income households, the plan allows these households to enjoy the same health benefit structure and provider access that others receive. The low cost of the Basic Plan itself limits the exposure of the public sector, and with a much-reduced administrative burden. Under this plan, the State would have no other role in the provision of health insurance or health care. A state that chooses to adopt this proposal should be able to use Medicaid dollars to defray the cost of underwriting coverage of the Basic Plan for needy individuals.

Finally, competition among insurers should help contain the administrative costs of providing insurance. Although insurers would be permitted to provide additional, supplementary or complementary policies, the Basic Plan, by definition, covers the most important insurable risks. On average, the premium for supplementary insurance services would impose premium costs on an annual basis that are higher in cost than acquiring the services on an out-of-pocket basis.

The insurance reform outlined above will stimulate consumer discipline of health care costs both through more cost-conscious decision-making encouraged by the Basic Plan features, but also by bringing consumer discipline back into the market for the insurance product itself. As discussed below, removal of the employer from the insurance transaction will generate increases in cash wages. For those who currently have employer-based insurance, the wage increases will be more than sufficient to support the consumers' obligation to buy the Basic Plan. In addition, however, adopting this reform would generate other benefits to both businesses and labor. These benefits result from the removal of the distorting effect of employer-provided health insurance.

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The Effects on the Economy and Jobs

To understand the effects on wages, firms and labor, it is important to recognize who pays the insurance premium under the current, employer-based scheme. Contrary to superficial appearances, it is the employee, not the employer, who pays the insurance bill. The employee pays this bill in the form of a reduction in cash wages received. Specifically, wages are lower than they otherwise would be by an amount equal to the insurance cost. If the value of the insurance to the worker were exactly equal to the premium, then the employee would be indifferent to receiving a larger cash wage without insurance or a cash wage that is lower by the amount of the premium.

In fact, however, the firm is often mandated by government regulation or collective bargaining agreements to spend more on insurance premiums than their cash equivalent value to the employee. Indeed, so many workers would rather have more cash and less insurance that there are often restrictions against an employer offering opt-outs to the insurance coverage. Since the plans offered by employers contain elements of premium costs that are eliminated by the Basic Plan design, the result of implementing the Basic Plan would be to raise wages by more than the Basic Plan costs for virtually all employees currently covered by employer-based insurance. Thus, for this group, wages would rise by more than the cost of the consumer-based Basic Plan.

Households that do not currently have employer-based insurance also are in a better position than they were prior to implementation of the proposed reform. They now have access to a low-cost “group rate” Basic Plan instead of facing only the option of expensive, individual plans. Thus, they are more likely to be able to afford at least the high deductible/high co-insurance version of the Basic Plan. For those whose wages are so low as to keep even this option out of reach, assistance with the Basic Plan premium would be provided.

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Curing Market Distortions

In addition, adoption of the proposed reform would remove some of the distortions to firm and labor market behavior that have impaired overall wage and economic health. The employer provision of health insurance has been shown to distort the firm's behavior and labor markets in several ways:

First, employer-based insurance has been shown to encourage use of part-time workers, temporary workers and outsourcing.¹¹ This allows the employer to avoid the higher total compensation rates associated with having to provide health insurance on top of a regulated or minimum wage. Under the proposed reform,

employers can return to the practice of providing full-time employment since they are unaffected by health insurance cost considerations. To the extent that the part-time employment arrangement was less efficient for the employer than full-time employment, the result will be an increase in economic productivity.

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Second, it has been shown that employer-based health insurance has reduced labor mobility by about 50 percent.¹² This has occurred because employees have been more reluctant to move to more productive and remunerative jobs out of fear of losing health insurance coverage. This has been a particular factor for employees with a chronic, pre-existing condition who may not qualify for coverage of the condition under a new insurer. The proposed reform removes this obstacle to labor mobility because there is no effect of pre-existing conditions on Basic Plan access or cost. Adopting consumer-based insurance of the type proposed here should thus have the effect of increasing productivity and worker compensation.

Finally, any region or state that adopts the proposed reform will have a competitive advantage in attracting firms that are sensitive to the level and risk of health insurance costs. This will be true particularly for firms that employ low-wage labor or healthy, young individuals who would prefer access to a high deductible, low-cost plan and a higher cash wage. Indeed, since the plan allows individual workers to customize their coverage to their individual needs, it improves labor and employment prospects for all types of workers and firms.

Summary

The implementation of this plan is minimally disruptive to the insurance industry compared to other, more draconian reforms such as single-payer universal insurance or employer-based mandates. Implementation does require a means of monitoring compliance with the compulsory participation and requires development of a scheme for assisting the truly needy who cannot afford even the Basic Plan premium. However, given the prospects for better control through consumer discipline of health care costs and the potentially large, positive effects on economic productivity and jobs, these are surmountable challenges.

The predictions of economic logic are borne out in practice. In Switzerland, where this approach has been in place for a decade, health care costs are one-third smaller than in the U.S., and the

Swiss believe the quality of their medical care is among the best in the world.¹³ Consequently, other countries, sagging under the weight of bureaucratic and inefficient single-payer plans are studying the Swiss system carefully. The State of Massachusetts recently has adopted a related reform, although the implementation is less streamlined and more complex than the one proposed here.¹⁴

In summary, health care reform can occur in a manner that provides equitable coverage with considerable freedom of consumer choice while removing obstacles to efficient labor utilization and onerous public bureaucracies. If the Swiss experience is any guide, the cost and quality of care are improved at the same time. In the popular business parlance, this reform could be a win-win-win-win proposition.

Appendix

In 2002 Cascade Policy Institute published Dr. Pozdena's report, "First, Do No Harm: Why American Health Care Policy is Failing, and How to Fix It." Part of the report was dedicated to exposing eight significant health care myths, and replacing them with their corresponding realities. Myth 1 is particularly relevant to his policy proposal presented in this paper, and so is presented here in slightly altered form. The full report is online at www.cascadepolicy.org/pdf/health_ss/I_121.pdf.

"Risk sharing through insurance is important and economically efficient when there are events that are rare, costly and difficult to predict."

Myth 1: The main health policy problem is too little health insurance

If one believed the popular press, all of our problems with health care would be solved if everyone had health insurance coverage. It is popular to bemoan the fact that too many households do not have health insurance, and that the poor cannot afford to pay out of their own pockets for insurance or care because of the high price of care.

This is the fundamental fallacy of modern health care policy. It myopically focuses on ubiquitous, comprehensive health insurance as the solution to the economical provision of good health care. This view ignores the fact that poorly implemented subsidization and over extension of health insurance are, in fact, the likely proximate *cause* of the rising cost of health care.

The reason is simple. When properly designed and applied, insurance provides an efficient means of *sharing risks*. Risk sharing through insurance is important and economically efficient when there are events that are *rare, costly and difficult to predict*. Earthquakes, sudden death, and house fires are such events, as is treatment for leukemia, a stroke or the unexpected complications of childbirth. Insuring such events makes good

economic sense because, though rare, such risks are financially devastating. Consequently, a rational, risk-averse individual will be willing to pay a little bit, along with others, to be insured against the consequences of such events. This, in fact, is the theoretical reason for the existence of the insurance market: insurance against rare, but financially catastrophic, events.

"[T]he pro-rata cost of sharing the burden of common and minor events through private or public insurance actually will be greater than the cost of bearing it individually because of the administrative cost of the insurance."

In contrast, many health events are so common and minor that they are likely to befall most everyone in the population, with the consequence that there is little advantage of risk sharing through insurance. Specifically, the *pro-rata* cost of sharing the burden of common and minor events through private or public insurance actually will be greater than the cost of bearing it individually because of the administrative cost of the insurance. In such cases, there is no *natural* insurance market. This is why routine house painting costs are not insurable, but a house fire is.

However, when insurance premiums are subsidized as a result of tax-exempt treatment of employer-based insurance, demand for insurance of minor, common events will increase. For example, one can be certain that insurance policies to cover painting your house *would exist* if their premiums were tax-deductible.

When insurance coverage is broadened to include common events, there is no significant risk-spreading function performed. What remains, however, is a powerful, distortionary phenomenon economists call *price illusion*. *Price illusion* occurs when the perceived price of something does not reflect the true cost of that good or service, and creates instead the illusion of low or even zero cost. The effect of *price illusion* is that we as consumers tend to not care about costs of the insured service, and behave accordingly, because someone else will pay for it. It is a basic precept of economics, however, that unless the consumer cares about the price of a service when making an individual spending decision, there will be no *price discipline* in the market. After all, the providers of the service have the opposite incentive: to make prices high!

The tax-advantaged treatment of health insurance generally, and the extension of this treatment to non-catastrophic care insurance in particular, has dramatically increased the importance of the *price illusion* in health care trends. In the medical care realm, about 80 percent of all medical visits involve relatively minor, commonly anticipated medical events. This includes such events as seeking care for common colds, flu, infections, minor injuries,

normal pregnancy, etc. Though there is little *risk-sharing* function performed by insuring such events, a potent *price illusion* effect is created which results in the false perception that the service is essentially free, at the margin.

“The over-consumption effect will dominate in markets where the supply of services is responsive to demand, and inflation will dominate in a market where the supply of services is relatively inflexible.”

Price illusion stimulates additional spending, with no assurance that the additional spending is cost-beneficial. Indeed, everything else being equal, the lack of consumer discipline in the process virtually guarantees that the additional spending will be excessive and inefficient. As in the case of a group of diners who agree beforehand to split the restaurant bill evenly, the insurance of common health care services causes us to all spend more than we otherwise would have. The result is over-spending, yielding either over-consumption of services or inflation in the price of services or both. The over-consumption effect will dominate in markets where the supply of services is responsive to demand, and inflation will dominate in a market where the supply of services is relatively inflexible. In the market for medical services, there are elements of both these supply conditions, with the result that there is both over-utilization and relative inflation of health care services. By this line of reasoning, it is apparent that the problem with American health care policy is not too *little* insurance, but too *much* insurance and dominance of the *price illusion* effect. American health care policy has virtually extinguished consumer price discipline, with the result that prices of medical services tend to inflate much more rapidly than otherwise.

The inflationary effect of excessive coverage can be documented by examining the pace at which the unit cost of medical services has risen with the broadening of insurance coverage. Even anecdotally, the coincidence of increased coverage and medical services inflation is clear. For example, in 1965 when Medicare was being debated, it was widely lamented that the cost of a day's hospital stay in 1963 was an outrageous \$40. After 35 years of expanded Medicare spending, the cost of hospital room and board (when billed separately from nurse and medical services) now exceeds \$500 per day in many urban markets. This is twice the cost that can be explained by general inflation alone. Similarly, a simple appendectomy that cost less than \$75 in the 1940s cost over \$800 by 1989 and costs in excess of \$3,000 today. This is nearly four times the cost that can be explained by general inflation alone. According to one analyst of the Medicare program, failure to anticipate the over-utilization and relative inflation caused by Medicare resulted in a six-fold underestimate in projected 1990 costs.

Using the available medical services price index data, the phenomenon can be demonstrated more comprehensively. Under the pressure of expanded government and private insurance coverage over the years, the price of medical services has risen more than twice the rate expected from general inflation factors (See Figure 1 online at www.cascadepolicy.org/pdf/health_ss/I_121.pdf).

The effect on utilization has followed a similar path. The *price illusion* created by broad health insurance or government health care provision has caused consumers to increase the consumption of health care services relative to other goods. Health care spending increased from less than four percent of per capita gross domestic product (GDP) to 12 percent in 1996 (and 14 percent today) (See Figure 2 online at www.cascadepolicy.org/pdf/health_ss/I_121.pdf). When the *price illusion* sparks such runaway growth in spending, of course, it is virtually certain that much of the growth is in the form of over-utilization and/or low-productivity expansions in the features of the services provided.

Endnotes

1. For a comprehensive discussion of this notion see Randall Pozdena, "First Do No Harm," Cascade Policy Institute, 2002. <http://www.cascadepolicy.org/pdf/health_ss/1_121.pdf>
2. See Amy Finkelstein, "The Aggregate Effects of Health Insurance," NBER, April 2006. <http://www.nber.org/~afinkels/papers/Finkelstein_Medicare_April06.pdf>
3. See <http://www.cagi.ch/en/Bien_se_soigner_en_Suisse.htm>.
4. Steve Buckstein, "Better, Cheaper Healthcare for Oregonians," Cascade Policy Institute, November 2004. <http://www.cascadepolicy.org/pdf/health_ss/2004_30.pdf>
5. Tanner, for example, argues, "The individual mandate opens the door to widespread regulation of the health care industry and political interference in personal health care decisions." See Michael Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work," CATO Institute, No. 97, June 6, 2006. Tanner is focused primarily on the arcane Massachusetts mandatory coverage plan. The plan proposed here does not have many of that plan's distasteful features and suggests means of limiting problems of coverage expansion. He also fails to appreciate the externality issue and its efficiency implications (see below).
6. In economic theory, cost-based pricing can improve efficiency only to the extent that such pricing is able to encourage resource-sparing changes in the allocation of real resources. An individual who unwittingly draws an adverse health event has no opportunity, after the fact, to reverse that event, and, by definition, before the fact they cannot be certain that such an event will, or will not, befall them. Thus, the incidence of involuntary health events has little or no elasticity (responsiveness) to the price of insurance. Thus, the only choice that society has is either to lose the productivity of that individual or find a means to provide remedial health services. Indeed, it is this inability to control or predict adverse health events, coupled with their link to economic productivity, that makes health insurance coverage of certain types of events good public policy from an efficiency standpoint.
7. See James G. Kahn, et al., "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals," Health Affairs, 24, No.6 (2005): 1629-1639 doi: 10.1377/hlthaff.24.6.1629.
8. Ibid.
9. There are some borderline issues in this regard that will have to be resolved. Inoculations and screenings for more serious conditions would be included in the Basic Plan, for example, if they were proven to avoid higher long term costs to consumers or reduced the burden of significant pandemic events.
10. Lucien Gardiol, Pierre-Yves Geoffard and Chantal Grandchamp, "Separating Selection and Incentive Effects: an Econometric Study of Swiss Health Insurance Claims Data," Working Paper No. 2003-27, Departement et Laboratoire d'Economie Theorique et Appliquee (Paris, France), November 26, 2003.
11. See Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," NBER Working Paper 11160. <<http://www.nber.org/aginghealth/spring05/w11160.html>>
12. See Bridgett C. Madrian, "Employment Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?," JSTOR: Quarterly Journal of Economics: Vol. 109, No. 1 (Feb., 1994), 27-54; "The Effect of Rising Health Insurance Premiums on Employment," NBER Website, July 4, 2006 <<http://www.nber.org/aginghealth/spring05/w11160.html>>; John Rosshiem, "Health Insurance Reform's Effect on Workers and Employers," <<http://content.salary.monster.com/articles/mass%5Fhealth/>>; and Gardiol, Geoffard and Grandchamp.
13. "In Switzerland, everyone is insured, and businesses don't pay," The Dallas Morning News, February 7, 2006. <http://www.dallasnews.com/s/dws/bus/stories/DN-swisshealth_07bus.ART0.State.Edition2.21730ee.html>
14. Among other differences with the plan proposed here, the Massachusetts plan is focused on the uninsured only, which raises some issues of efficient risk pooling. In addition, the plan retains the employer as the conduit for others' insurance, imposing penalties on employers that do not offer the minimum plans. This unnecessarily imposes distortions on labor market behavior of employers and employees. See <<http://www.mass.gov/legis/bills/house/ht04/ht04850.htm>>.

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