Shannon:

Thanks for the response.

My knowledge of the insurance industry is, like my knowledge of most esoteric subjects, self taught. I have no life. [If you want to see how dull life can be, go to my web site: http://scott-juris.blogspot.com.]

This knowledge has been supplemented by life experience that includes having served as a senior legal executive at two public companies and private practice at a national law firm that had a practice group that represented corporate insureds in coverage disputes (a practice that I avoided like the proverbial plague).

My mentor at the law firm suckered me into giving a series of lectures on insurance and bankruptcy law and I later taught these subjects at summer seminars at Vermont Law School.

As for health coverage, while in private practice I represented a 21 year old roofer with testicular carcinoma, *pro bono* of course, in one of the early autologous bone marrow transplant cases. From this case, I picked up a little knowledge of the health care benefit system and a vast knowledge of platinum-based oncology therapeutics.

I have no interest, pecuniary or otherwise, in insurance companies or the insurance industry. I just want to contribute to the public policy debate. And, like I said, I have no life.

Some responses for you:

1. You are correct that there is a measure of risk transfer within enterprises that provide benefits (employers, unions, etc.) to the extent that premium payments are not correlated with risk. [Some companies do charge premiums that vary depending on compensation, but compensation does not correlate with risk.] My point was that there is no risk transfer from the employer to an insurance company. If the employee/consumers understood the system they would realize that money spent on health care is money that they could be receiving (at least in part) as compensation. There is no unrecoverable "sunk cost" premium paid to an "insurance company", and the employer is not indifferent to the cost of care above the amount of a fixed premium.

2. I am not sure I understand your second point, and I also have some questions that may be based on misunderstanding, so bear with me. If I understand your point, there are regional differentials in health care spending after adjustments for basic population health, variations in malpractice costs, and available resources. This remaining differential must, therefore, be the result of demand. Is this data adjusted for other business cost differentials (rent, labor, insurance (other than professional liability), taxes, etc.? Also, is it adjusted for patient population liquidity? (The population in Nevada may have a greater ability to pay "co-pays" and deductibles than the population in Virginia.) I do not know what the weighted average marginal federal income tax rate is, but why do you believe that imposing an additional cost on consumers in that amount would not significantly affect demand?

3. The idea of requiring employees to purchase their own insurance is another idea that I think has a lot of merit and might also cure the problem. You are correct that the employer-pays system is nutty and is, as I pointed out, an historical accident. The Great Depression and World War II were traumatic events in our history that will continue to affect us for some time to come.

My knee jerk response to employee insurance purchase was that it is a variation on my tax proposal (because it is just another way of shifting a large part of the cost to consumers), but on

further reflection I now see it as fundamentally different, but potentially just as meritorious (but, unfortunately, just as much of a political non-starter).

First, it would be true, risk transfer insurance because holding insurance would be a condition of employability, so it would eliminate the adverse selection problem (the incentive for healthy people not to purchase insurance). There would, therefore, be a healthy pool of employees sharing the cost of care with the sick.

Second, the states (God forbid, not the federal government) could essentially "write" the policies the way they do now for homeowners' insurance policies. [Homeowners' insurance policies are puchased by homeowners, but really protect lenders. Without standardized policy coverage, lenders would have to worry about coverage exclusions contained in low cost policies purchased by borrower/homeowners. So, state legislatures specify what homeowners' insurance policies must cover. They could do the same for health insurance policies.]

Third, if employees purchased policies, the federal government would no longer have to backstop the system with ERISA. This would eliminate virtually all of the "managed care" concerns. The reason why is complicated, so stay with me.

The relationship between and insured and insurer is inherently unequal. The resources and bargaining power of the insurer are vastly greater than those of the insured. So, the insurer has an incentive to breach the insurance agreement and not provide the coverage promised. (The life insurance company shows up at the breadwinner's graveside and says to the grieving widow, "Look, I know the policy says $100 thousand, but we think we've got some defenses to coverage, so why don't you just take $50 thousand. It's more than you'll get from suing us after paying the lawyers and expert witnesses. And, you know that trials and appeals could take ten years.")

To eliminate this incentive, the law has developed the concept of the bad faith claim. An insurance company can deny coverage, but it does so at the peril of a bad faith claim by the insured that, if successful, entitles the insured to punitive damages (typically in amounts sufficient to deter the insurance company from ever doing it again, which in the eyes of most juries is a very large number). So, insurance companies are very careful in denying claims. The risk of bad faith denial claims is so great that even when dealing with large corporations insurance companies commonly provide coverage under a "reservation of rights" where they pay, but simultaneously seek a judgment from a court that they do not have to and that the insured has to reimburse them.

When the federal government undertook to guaranty employer creditworthiness for health care expenses under ERISA, Congress did not want to subject the Treasury to the risk of bad faith claims. So, ERISA provides that all health coverage disputes must be heard in federal court, without a jury, and without the availability of bad faith claims or claims for punitive damages. The health care providers - employers and the insurance companies who process claims on their behalf - are, therefore, incentivized to abuse their unequal bargaining position relative to their employee/insureds. Hence, "managed care." [This is not meant to be critical of employers or insurance companies. Their acts are economically rational.]

This explains, by the way, why you almost never hear of "managed care" type complaints from auto accident victims. Auto insurance is not covered by ERISA and the insurance company is subject to bad faith claims for wrongful denial of coverage.

There is no need for the federal government to guaranty the creditworthiness of private insurance companies dealing directly with private individuals because the states already do that quite effectively. The problem came up with corporate employers because they are not required to deal with state-licensed and regulated insurance companies (called "admitted" companies), but

can deal with insurance companies (often "captive" companies that they set up themselves in convenient jurisdictions like Bermuda) that do not necessarily maintain sufficient reserves to meet claims.

Fourth, you are correct that employers would save the cost of providing health care benefits and at least part of this saving could be passed along to the employees as compensation that may, or may not, offset the employees' cost of health insurance. Except for low income individuals, I would not allow the employees to pay for health care out of pre-tax income and certainly would not allow a tax credit for health insurance expenses. The latter would just recreate the current problem.

Fifth, I believe that employees would be very sensitive to cost under an employee insurance purchase system because they would be at risk of premium increases or cancellation if their use of the system was excessive. The incentive is the same as with auto insurance where insureds tend to bear manageable, yet arguably insured, costs themselves for fear of rate increases.

I think that any system that gives one party to the transaction an interest in controlling the cost will reduce the overtreatment problem that you are concerned about. I would start with one of these ideas and see how much of a problem is left.

The other problem that I see in the health care industry is an unsustainable business model. Not only do providers get paid regardless of outcome, they get paid regardless of experience. A doctor in his first year of practice and a doctor with 30 years experience get paid similarly (not necessarily identicially) for most procedures. And, current regulation of the medical profession prohibits the "leverage" business model seen in the legal profession.

When I was young, doctors were the highest paid professionals in town. Lawyers were right behind them.

Now, (except for a few superstar specialists) doctors are not even close to lawyers. (The average partner at my East Coast law firm makes in excess of $750 thousand annually. Even at the midwest firm I recently left, the average partner makes $300 thousand. Few doctors come anywhere near this.) This is because lawyers developed a leverage business model where one lawyer supervised, and profited from, the work of numerous junior lawyers and paraprofessionals. Depending on how much leverage you want to take on, profit potential is essentially infinite.

Doctors, in large part, continue to rely significantly on their individual charges, and the amount of patients that can be seen in a day is finite. So, we have law firms with thousands of lawyers in offices all over the world, but doctors continue to practice in small groups.

Most medical practice by doctors is a misallocation of resources. Nurses, even trained high school graduates, could do virtually everything most doctors do and could do it much more cost effectively. Most pediatric or general family practice could be done by paraprofessionals under supervision of a doctor at ratios of 10 or 20 to 1.

Yes, a doctor can make difficult diagnoses that paraprofessionals cannot, but such diagnoses are rare and an initial mistake by a paraprofessional would rarely be consequential (with appropriate screening tools incorporated into the intake and treatment system). Doctors could focus on improving the quality of care of the patients they do see and on generally improving health care quality (hospital infection rates, etc.). Under the current system, doctors have to see as many patients as possible in order to make a living and simply do not have time for more professional concerns.

Hope you find this interesting