Michael,

Thanks for your very interesting and thorough analysis. (And I'm curious how you know so much about the insurance industry.)

I disagree with a couple of points. One, there is in fact a pooling of risk in health insurance in the sense that young people rarely get sick and old people do regularly. Unlike life insurance, the amount an employee pays for health insurance is not graduated accurding to age. It is often regressive in the sense that employers ask lower wage -- younger -- employees to pay the same percentage of their wages toward their health insurance. The marginal cost to the lower wage employee is greater, and they get sick less often than older employees, who generally make more.

My second cavil concerns the source of overtreatment. You assume, like many Americans and many economists, that a large source of overtreatment is patients themselves who run to the doctor at every opportunity because they have little or no financial disincentive to do so. If that were true, then there would be far less variation in health care spending across geographic regions of the country (once you account for differences in underlying levels of health). Underlying health accounts for about 20-30 percent of the variation. Differences in malpractice rates (and thus differences in defensive medical practice by doctors) accounts for about 7 percent. About 40 percent is supply of doctors and hospital resources. That leaves about 25 percent for everything else, including patient demad. Yes, it would help if patients were more conscious of their medical consumption. But that would not change the problem of oversupply and overtreatment substantially.

I support Senator Breaux's (and Karen Kornbluh's in the same issue of the Atlantic) proposal that Americans purchase their own insurance, and that all Americans be required to purchase catastrophic insurance. Having employers pay is a nutty system -- employees have on average about seven different carriers over their lifetime, giving no single insurer an incentive to provide preventive medicine such as weight reduction or careful monitoring of diabetes. Low income citizens would need help purchasing insurance. I for one would not choose to purchase insurance that pays for routine office visits -- which is all I have ever had in the 20 years I've been an employee. I've paid far more into health insurance than I have taken out of it, and I would have been happy to pay for those few office visits. But I do want to be covered for brain cancer, or a terrible accident. (Health problems are the number one reason for declarations of personal bankruptcy.)

I wonder if the Breaux/Kornbluh plan accomplishes what your idea does? I would want my employer (of course, I'm a freelancer so I have no employer) to pay me more if he or she does not need to provide health coverage. My taxes would go up from my increased income. I don't know the numbers, but it is conceivable that that increase would provide enough to subsidize the purchasing of insurance for low income families. Or it might not

if we continue to allow a deduction for health care costs. Of course, a cornerstone of that plan is that everybody is required by law to purchase insurance, or the system will implode as younger healthier people opt out.

The most vexing problem is figuring out how to reduce overtreatment -- because that involves changing the behavior of doctors and hospitals. I think the term "herding cats" aptly describes what it's like to try to get doctors to practice medicine differently.

I would be pleased to hear more from you about health care reform.

Best regards,

Shannon