GOLDCARE INSURANCE

WHITE PAPER · HEALTH POLICY

The Great Health Insurance Mistake

How Tax Policy Broke American Healthcare

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Table of Contents

I. The Original Purpose of Insurance

Before discussing reform, we must be clear about what insurance actually is. Insurance exists to solve a specific economic problem: some events are rare, unpredictable, and financially devastating. A house fire, a fatal car accident, or a major medical catastrophe can produce losses far beyond what most individuals could absorb on their own. Insurance pools that risk. Many people pay relatively small premiums so that the few who experience catastrophic loss are protected from financial ruin.

Providing that protection requires a standing structure. An insurance company must hold capital, maintain reserves, employ underwriters and claims staff, build compliance systems, and remain prepared at all times to pay large losses. That readiness must exist whether or not a catastrophe occurs. Most policy holders will never file a catastrophic claim, yet insurers must remain fully prepared in case they do. The cost of that preparation—reserves, staffing, and infrastructure—is built into every premium. Insurance is expensive because preparedness is expensive.

People accept that cost because they are purchasing protection against financial ruin, and they accept the friction that accompanies it. When a homeowner files a major claim, documentation is required. Inspections occur. Adjusters evaluate the loss. The process can be slow and bureaucratic. But when the potential loss is hundreds of thousands of dollars, that friction is rational. It becomes intolerable when applied to routine, predictable expenses that could simply be purchased directly.

The same principle exists in medicine. As an emergency physician, I worked in departments that had to be fully staffed and stocked every day, whether or not a trauma patient arrived. That readiness carried cost even on quiet nights. Insurance operates the same way: you are paying for the readiness structure whether or not you ever use it.

> **Insurance exists to protect against rare, high-cost, unpredictable events. Using it for predictable spending is like using an emergency department for something minor. You are not just paying for the visit—you are paying for the entire trauma-ready infrastructure.**

For most forms of insurance—auto, home, and life—the distinction between catastrophic financial loss and routine spending remains intact. Health insurance in the United States gradually moved in a different direction.

A. Defining Insurance Properly

Catastrophic risk pooling works because the loss is uncertain. A house may burn down. A car accident may occur. A sudden illness may strike. No one knows when—or whether—those events will happen. Pooling stabilizes that uncertainty.

But when an expense is expected, it is not risk. It is consumption.

An annual physical is expected. A routine prescription refill is expected. Common diagnostics are expected. These are not rare events; they are part of ordinary life. When predictable expenses are routed through insurance, risk is no longer being pooled. Consumption is simply being prepaid. Prepayment smooths cash flow. Insurance protects against ruin. Using insurance to "prepay" routine spending adds administrative cost without providing risk protection. It increases cost without increasing value.

B. The Actuarial Logic of Insurance

Insurance and ordinary purchases operate on different principles. Insurance pools uncertain risk across many participants so that the few who experience catastrophic loss can be protected. Ordinary purchases function differently. When individuals buy routine goods or services directly, they see the price. Cost and quality are visible at the point of decision, and competition can function. When predictable services are routed through insurance, price visibility disappears. Payment flows through reimbursement schedules rather than posted prices, and administrative systems emerge to manage billing, coding, and approval. What begins as payment management gradually evolves into decision control.

If an expense is expected, insuring it does not spread risk. It requires payment in advance for services expected to occur later. Administrative layers arise to manage those transactions, and their cost is embedded in premiums and largely invisible to the patient. The distinction between risk protection and routine financing determines whether markets remain transparent and competitive—or become opaque and structurally distorted.

C. The Central Principle of Insurance

Insurance provides financial protection against uncertain future loss. It exists to absorb rare, destabilizing events. But when routine purchases are treated as insurable risk, the structure changes. The consumer no longer behaves as a purchaser. The insurer becomes a gatekeeper.

Administrative layers expand to manage reimbursement, coding, and authorization. The system grows more complex—and more expensive—because it is financing predictable consumption rather than pooling uncertainty.

An insurance system that functions as a payment mechanism for known or ongoing expenses inevitably loses transparency and price discipline. Competition weakens because the person consuming care is no longer making the economic decision at the point of purchase.

That is the hinge on which the modern system turns.

Once routine care is routed through insurance, the person receiving care no longer directs the purchase. The economic relationship changes: the patient is no longer the customer. When the consumer is no longer the purchaser, the normal disciplines of a market weaken. Prices become opaque, administrative systems expand, and decision-making shifts away from the person receiving the service.

No single generation designed the modern health insurance system. It emerged incrementally. A wartime tax accommodation became permanent law. Employers adopted coverage because the tax code rewarded it. Insurers expanded benefits because comprehensive coverage was more tax-efficient than wages. Administrators built systems to manage the resulting complexity. Each step was rational in isolation. Over time, however, those adjustments reorganized the system around a different set of incentives. What began as catastrophic insurance gradually became a comprehensive prepayment system for routine care. Once that structure took hold, institutions formed around it, and reversal became increasingly difficult.

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[1] Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, American Economic Review 53, no. 5 (1963): 941–973.

II. The Structural Pivot: Federal Policy Redefined Health Insurance

Imagine if automobile insurance worked the way health insurance does today.

Suppose that in 1943 the IRS ruled that employer-paid auto insurance premiums were tax-free, while individually purchased auto insurance remained taxable. In 1954, Congress codified the exclusion permanently.

Employers competing for labor would quickly begin offering auto insurance as a workplace benefit. Because the exclusion was uncapped, the larger the policy, the larger the tax-advantaged compensation. What began as catastrophic collision protection would not remain so. Insurers would gradually expand coverage to include oil changes, tire rotations, brake service, batteries, roadside assistance, rental coverage, and other routine costs of operating a vehicle. Each additional covered service would increase the tax-advantaged portion of compensation, making broader plans economically attractive to both employer and employee.

As routine operating costs became "covered," drivers would lose price sensitivity at the point of service. Repair shops would negotiate with insurers rather than customers. Networks would form. Prior authorization would emerge. Billing codes would multiply. Administrative layers would expand to manage utilization and reimbursement. Plan design would increasingly optimize for employer negotiation rather than individual price transparency.

The subsidy would not merely inflate premiums; it would expand the automotive market itself. When a substantial share of ownership and operating costs is invisibly financed through tax-advantaged employer benefits, the perceived price of car ownership falls. More individuals would purchase vehicles who otherwise might not. Drivers would select more expensive models, drive more miles, and consume more covered services because the marginal cost at the point of use would be reduced. Utilization would rise, administrative overhead would compound, and premiums would swell to absorb both expanded coverage and expanded demand.

What began as $2,000–$3,000 annual accident protection could plausibly evolve into $12,000 or even $20,000 comprehensive "mobility coverage" per vehicle. At first the system would appear generous and efficient. But as routine expenses were routed through tax-favored third-party payment, premiums would expand to absorb both broader coverage and rising

utilization. Total automotive spending would rise as a share of household income and national output—not because cars became inherently less efficient, but because the payment structure weakened price discipline and rewarded expansion.

This thought experiment describes, in simplified form, what actually happened to health insurance in the United States. Federal tax policy gradually transformed health insurance from catastrophic risk protection into a comprehensive prepayment system for routine care.

A. The Tax Policy That Changed Health Insurance (1942–1954)

The pivotal shift in American health insurance began during World War II. In 1942, the federal government imposed wage controls to restrain inflation, limiting employers' ability to compete for workers through higher salaries. Employers responded by expanding non-wage compensation, including health benefits.

In 1943, the Internal Revenue Service ruled that employer-paid health insurance premiums would not be treated as taxable income to employees. Individually purchased insurance, however, remained payable with after-tax income. In 1954, Congress codified this exclusion in what is now Internal Revenue Code §106, converting what had begun as an administrative accommodation into permanent statutory policy.

This created a powerful tax asymmetry between purchase channels. Employer-sponsored insurance became economically cheaper than identical coverage purchased independently. In a 35 percent tax bracket, a $10,000 employer-provided policy costs $10,000 of the employee's compensation, paid to the insurer rather than to the worker. To buy that same policy independently, the employee would first need to earn approximately $15,400 in wages. The tax exclusion effectively made employer-sponsored insurance roughly one-third cheaper than identical coverage purchased individually.

In practice, the difference was even larger. Employer-paid premiums were also exempt from payroll taxes for both employer and employee (7.65 percent each). When payroll taxes are included, shifting compensation from wages into health insurance could reduce the effective tax burden by more than 40 percent for many workers. Both sides of the employment relationship benefited simultaneously, which allowed the model to spread rapidly.

Over time, this tax structure produced several important shifts. Insurance became embedded in the employment relationship as a component of compensation rather than a personal financial decision. Employers became the primary purchasers of coverage, selecting plans on behalf of their workforce. Because the exclusion was uncapped, the tax benefit increased with

the size of the premium. The larger the policy, the larger the tax-advantaged portion of compensation. This structure naturally favored the broadest coverage over narrow catastrophic protection.

Insurers expanded plan design accordingly. Routine medical services gradually migrated into the insurance architecture because the tax code rewarded shifting compensation from wages into insurance benefits.

The expansion of comprehensive coverage was reinforced by normal behavioral preferences. Many individuals prefer predictable payroll deductions to paying out-of-pocket at the point of care, even when the actuarial value is lower. As comprehensive health benefits became standard among large employers, competitive labor markets reinforced their adoption.

What began as catastrophic insurance gradually evolved into a system in which routine medical spending was routed through third-party payment. Once that structure took hold, employers, insurers, and administrators became the central actors in the purchase of healthcare coverage. Economists have recognized for decades that the tax exclusion for employer-sponsored insurance encourages overinsurance and weakens price discipline by shielding routine medical spending from direct consumer payment. The exclusion of employer-sponsored health insurance premiums from income and payroll taxes is the largest tax expenditure in the federal tax code, costing the federal government over $400 billion annually and strongly encouraging compensation to flow through employer-mediated insurance rather than wages.

B. Institutional Entrenchment of the Employer-Based Model

The employer-based model did not remain a wartime anomaly. Over subsequent decades, federal policy and regulatory structures reinforced and entrenched it until employer-sponsored coverage became the dominant channel through which working-age Americans obtained insurance. Coverage became tied to employment status rather than individual choice, reducing portability and making insurance contingent on job continuity.

Because tax advantages were concentrated within employer-sponsored plans, individuals purchasing insurance independently faced a persistent structural disadvantage. Workers were incentivized to remain in jobs to preserve health benefits, while employers became the central intermediaries in insurance selection. What began as a compensation substitute matured into the default purchasing mechanism for most non-elderly Americans. Today roughly half of Americans receive coverage through employer-sponsored plans, and the tax exclusion that supports this structure remains uncapped.

Several major policy developments reinforced this architecture over time.

1. ERISA Governance and Preemption (1974)

The Employee Retirement Income Security Act (ERISA) federalized the governance of employer-sponsored benefit plans. The law preempted many state insurance regulations for self-funded employer plans, allowing large employers to operate under a uniform federal framework. This strengthened employer control over plan design and further marginalized individual market alternatives.

2. HMO Act of 1973

The Health Maintenance Organization Act promoted prepaid, network-based care models and encouraged the growth of managed care organizations, accelerating the expansion of third-party management structures within health insurance.

3. DRG Payment System (1983)

The introduction of Diagnosis-Related Groups (DRGs) into Medicare hospital reimbursement replaced retrospective cost reimbursement with fixed payments based on diagnosis categories. While designed to control costs, the system expanded coding systems and administrative infrastructure that became embedded in hospital finance and insurance operations.

4. Managed Care Expansion (1980s–1990s)

Throughout the 1980s and 1990s, employer-sponsored insurance increasingly relied on managed care mechanisms such as provider networks, prior authorization, utilization review, and negotiated reimbursement schedules. Because employers were the primary purchasers, insurers optimized plan design for corporate benefit negotiations rather than individual consumer choice.

5. Affordable Care Act Architecture (2010)

The Affordable Care Act expanded coverage but preserved the employer-based structure. Federal benefit mandates, exchange frameworks, and subsidy systems layered additional regulatory architecture onto existing insurance markets while maintaining employer-sponsored coverage as the primary channel for working-age Americans.

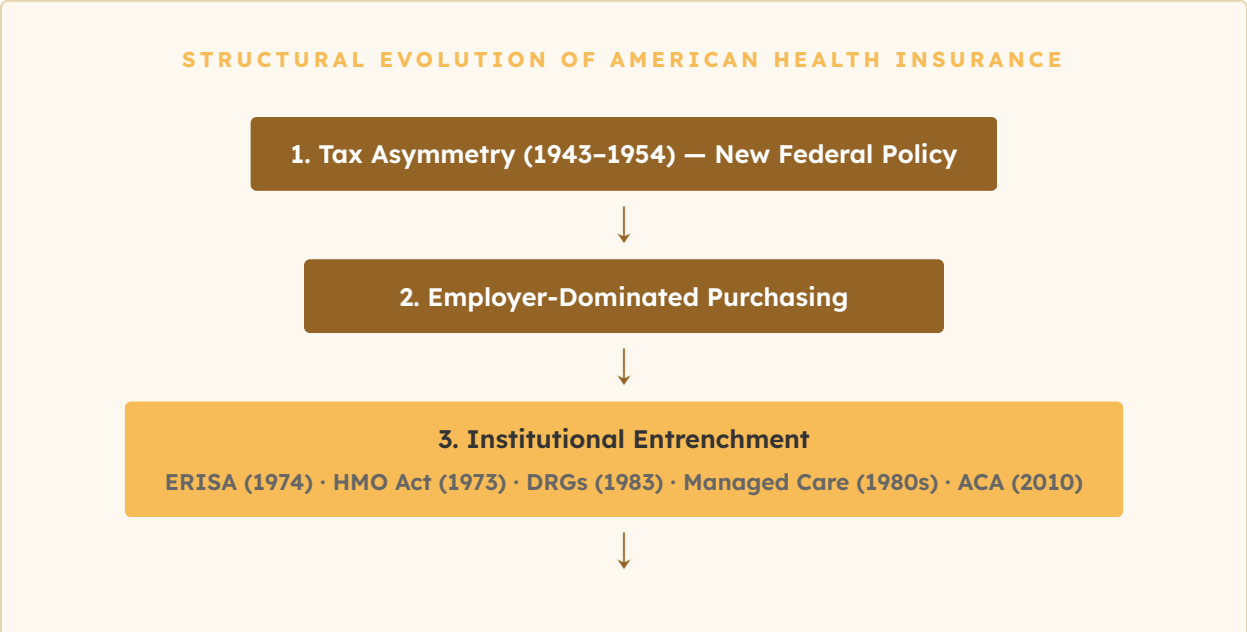
By the early twenty-first century, employer-based insurance had become the default architecture of American healthcare financing. Once coverage became embedded in employment, insurers began designing products primarily for employers rather than individuals, further distancing patients from the purchase of their own care.

Recent policy developments reflect attempts to loosen the employer-centered structure without fundamentally altering it. Individual Coverage Health Reimbursement Arrangements (ICHRAs), introduced in 2019, allow employers to provide workers with a fixed tax-advantaged contribution that employees use to purchase their own insurance. The employer funds the benefit but no longer chooses the policy.

ICHRAs illustrate the system straining against its own architecture. Even with a tax code that heavily subsidizes employer-sponsored insurance, employers are experimenting with arrangements that move purchasing authority back toward individuals.

C. The Structural Reorientation

The cumulative effect of these developments was not merely expanded coverage. It altered who controlled the purchase of healthcare. By favoring employer-sponsored insurance over direct purchase, federal policy gradually shifted economic authority away from patients. Employers selected plans, insurers negotiated reimbursement systems, and administrative intermediaries governed access and utilization. Insurance markets adapted to this hierarchy, designing products primarily for employer contracting and regulatory compliance rather than for individual purchasing transparency.



4. Structural Inversion — Patient No Longer the Primary Purchaser

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[2] Melissa A. Thomasson, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," American Economic Review Papers & Proceedings 93, no. 2 (2003): 137–142. Internal Revenue Code §§ 106, 3121(a)(2).

[3] Melissa A. Thomasson, "The Importance of Group Coverage," 137–142.

[4] Mark V. Pauly, "Taxation, Health Insurance, and Market Failure in the Medical Economy," Journal of Economic Literature 24, no. 2 (1986): 629–675.

[5] Kaiser Family Foundation. What Does the Federal Government Spend on Health Care? 2025.

III. Incentive Inversion

Incentive inversion occurs when the person paying for a service is not the person directing the purchase.

Once purchasing authority migrated away from patients, the economic incentives within the system inverted. When the buyer and the payer are no longer the same person, the normal economic discipline present in most markets weakens.

Over time, the American healthcare system reorganized around this misalignment. The person receiving care remained financially responsible through forgone wages and premiums but increasingly lost control over how care was purchased. Employers selected insurance plans, insurers designed reimbursement structures, and administrative intermediaries governed access to services. By the time the patient arrives in the clinic, the economic architecture of what will be offered has already been fixed.

A. Structural Misalignment: Who Pays vs. Who Decides

The mediated employer-based system separates economic responsibility from purchasing authority. The three principal participants in healthcare transactions—patient, physician, and employer—occupy roles that differ sharply from those found in most markets.

1. The Patient

The patient ultimately finances the system but does so indirectly. Employer-paid premiums are funded through compensation that would otherwise appear as wages. Employees therefore bear the economic cost of coverage through forgone salary, yet they do not select the insurer, negotiate the contract, or design the benefit structure. Pricing is embedded in reimbursement schedules rather than visible at the point of care. The person receiving treatment therefore finances the service but does not direct the purchase.

2. The Physician

Physicians deliver care but do not set prices in a conventional market sense. Reimbursement is determined through negotiated contracts, fee schedules, Diagnosis-Related Groups (DRGs), Relative Value Units (RVUs), and regulatory constraints. Network participation governs access to patients, while prior authorization and utilization management shape treatment pathways.

Clinical judgment therefore operates within administrative boundaries that determine how care is financed. The physician is neither a typical vendor negotiating price directly with a consumer nor a fully autonomous professional setting independent terms of service.

3. The Employer

Employers select the insurance plan and pay the premium to the insurer. Plan design, network structure, contribution levels, and benefit features are negotiated at the firm level as part of compensation strategy. Health insurance becomes a line-item expense within corporate budgeting and labor management. Although employers make the purchasing decision, they do not consume the care. The cost of premiums is ultimately borne by employees through wage tradeoffs, while purchasing authority resides with the firm.

In this structure, the economic actor and the economic decision-maker are no longer the same person.

B. System Response: Intermediaries and Administrative Architecture

Once purchasing authority separated from the person receiving care, intermediaries became necessary to manage the system. Insurance ceased to function primarily as risk pooling and increasingly became a payment infrastructure through which healthcare transactions were administered.

Insurers expanded beyond underwriting catastrophic risk into network construction, reimbursement negotiation, utilization management, and benefit design. Pharmacy Benefit Managers emerged to manage drug formularies and pricing within employer plans. Hospital systems consolidated to negotiate from scale, while benefit consultants and third-party administrators expanded to manage contracts, compliance, and reporting obligations.

Healthcare transactions increasingly passed through institutional negotiation rather than direct exchange. Payment flowed through contracts, coding systems, and reimbursement formulas rather than through visible prices negotiated at the point of service.

Several operational mechanisms emerged to govern this mediated payment structure.

1. Administrative Controls

Provider networks determine which physicians and facilities are eligible for reimbursement. Prior authorization requires approval before certain services are covered. Coverage rules, referral requirements, and utilization review protocols determine whether treatment qualifies for payment. Access to care therefore becomes governed by administrative eligibility rather than direct exchange between buyer and seller.

2. Payment Engineering

Payment is structured through technical reimbursement formulas rather than negotiated prices. Diagnosis-Related Groups determine hospital reimbursement, while Relative Value Units assign standardized values to physician services. Medical Loss Ratio requirements regulate insurer spending, and risk-adjustment mechanisms redistribute funds across insurance markets. These systems do more than process payment; they shape incentives. Revenue flows according to coded categories and regulatory frameworks rather than direct consumer purchasing decisions.

3. Pricing Opacity

Under mediated payment, prices are rarely posted or negotiated directly with patients. Pharmaceutical formularies determine which drugs are preferred and reimbursed. Rebate arrangements between manufacturers and intermediaries influence pricing but remain invisible at the point of care. Billing typically occurs after the clinical encounter through layered claims processing. Without visible price at the moment of decision, meaningful comparison becomes difficult.

4. Market Concentration

As negotiation replaced direct exchange, scale became a primary source of bargaining power. Insurers consolidated to strengthen negotiating leverage with provider systems. Hospitals merged into networks, and physician groups increasingly integrated into large health systems. In a system structured around institutional contracting, larger organizations negotiate more effectively. Economic decision-making therefore moved further away from the individual consumer.

C. Why the System Persists

Once established, the mediated employer-based system proved difficult to reverse. Several reinforcing forces stabilized the structure.

1. Tax Preference

Federal tax policy continues to favor employer-sponsored insurance over individually purchased coverage. Compensation routed through employer-paid premiums avoids income and payroll taxation, producing an effective tax subsidy that can exceed 40 percent compared with wages used to purchase insurance directly. Economists widely recognize that this tax exclusion lowers the effective price of insurance and encourages broader policies than individuals would otherwise purchase. As long as this asymmetry persists, the employer channel retains a structural price advantage.

2. Exit Friction

Because employer-sponsored coverage pools a large share of working-age participants, leaving the system often means entering a smaller and less competitive individual market. Even when alternatives exist, the economic penalty discourages experimentation and reinforces reliance on employment-based coverage.

3. Institutional Entrenchment

Over decades, insurers, hospital systems, consultants, administrators, and large employers organized their operations around mediated payment. Revenue models, staffing structures, regulatory compliance systems, and contractual relationships evolved within this framework. Structural reform would disrupt these established operating models across multiple sectors.

4. Complexity and Opacity

Administrative layering gradually obscured pricing and payment mechanisms. Networks determined access, reimbursement schedules replaced posted prices, and billing codes multiplied. Without clear pricing or direct purchasing authority, the ordinary economic restraint present in most markets weakened.

SYNTHESIS

The system did not merely drift from its original purpose; it reorganized around a different set of incentives. Once the patient and the buyer separated, and once tax policy favored mediated payment over direct purchase, the system no longer contained a natural mechanism for self-correction. When the person consuming care does not control the purchase under visible price conditions, normal economic restraint weakens. The modern employer-based system institutionalizes that dynamic.

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[11] Joseph P. Newhouse et al., Free for All? Lessons from the RAND Health Insurance Experiment (Cambridge, MA: Harvard University Press, 1993).

[12] Bernadette Fernandez and Annie L. Mach, Employer-Sponsored Health Insurance: Background and Issues, Congressional Research Service, R43181 (Washington, DC: CRS, 2023).

IV. Consequences of Incentive Inversion

Employer-sponsored coverage is financed through worker compensation that would otherwise appear as higher wages. As health insurance premiums rise, wage growth correspondingly slows. Employees experience coverage as an employment benefit, but its cost is embedded in forgone earnings. Economists have long recognized that most employer-paid premiums are ultimately borne by workers through lower wages over time.

Even when coverage appears comprehensive, the financial exposure faced by households is typically far greater than participants expect. Insurance marketing emphasizes the deductible as the key threshold of liability, but the deductible is not the true limit of out-of-pocket cost. Most policies layer additional financial obligations through coinsurance, copayments, exclusions, and out-of-pocket maximums. In practice, a plan marketed as having a $5,000 deductible may expose a household to total out-of-pocket liability exceeding $15,000 before full coverage applies. The difference between the advertised deductible and the actual financial exposure becomes visible only when a serious medical event occurs.

The result is a three-way squeeze for households. Insurance is expensive, it narrows choice, and it still leaves families exposed to substantial financial risk. What appears to be financial protection functions very differently in practice: a system that obscures prices, restricts choice, and still leaves households responsible for significant costs.

The ethical implications are equally significant. Informed consent requires that individuals understand the full implications of a decision—both medical and financial. In a mediated system, the financial dimension is largely obscured, and the medical dimension partially filtered. Coverage rules, network restrictions, and reimbursement policies determine which medications are preferred, which specialists are available, and which procedures are considered reasonable.

A. The Patient: From Consumer to Beneficiary

Consider how a parent manages a toddler's tantrum over what to wear. The wise parent redirects the child by offering two dresses—blue or red. The child deliberates carefully and selects one, believing she has chosen freely. But the full range of options was never presented. There were also the purple and green dresses, not to mention pants, shorts, or anything else in the closet.

That is the structure of modern medical choice. The patient consents—but only within a curated framework. By the time the physician enters the room, the menu has already been shaped by insurers, employers, and coverage rules. The consequences of incentive inversion become most visible in ordinary clinical encounters.

Consider a common emergency department visit: a patient presenting with chest pain. The clinical probability of a serious cardiac event is extremely low, yet the reimbursement structure strongly favors hospital admission and additional testing. Historically, a physician's obligation was to recommend only what was medically necessary for the patient. Today, physicians practice within reimbursement rules, liability pressures, and institutional protocols that make discharge difficult even when clinical judgment supports it. The patient believes the physician's recommendation reflects purely medical judgment, but the decision is shaped by structural forces the patient never sees.

> If the doctor is not free to advise, the patient is not free to choose.

B. The Physician: From Professional to System Operator

The same structural shift has transformed the professional life of physicians.

Throughout most of modern medical history, physicians set their own fees, explained them to patients, and the two parties decided together how to proceed. The economic conversation and the clinical conversation were part of the same relationship. Physicians were responsible both for the advice they gave and the terms under which care was delivered.

Within the modern insurance system, that structure no longer exists. Physicians appear to deliver care, but the practical boundaries of what they can offer are determined elsewhere. Those parameters have been negotiated years earlier—between employers and insurers, insurers and hospital systems, regulators and contractors. By the time a patient enters the exam room, the financial architecture governing that encounter has already been fixed.

Language itself reflects the shift. Physicians were called doctors. Today they are "providers." No patient has ever said, "I hope I can see a provider today." The term is administrative. It reduces a profession to a billing category—interchangeable, network-listed, reimbursable.

The transformation is most visible in the modern electronic medical record. EMR systems were designed primarily to capture and defend reimbursement classifications rather than to facilitate clinical communication. Templates, checkboxes, and documentation prompts are calibrated to coding requirements. Physicians therefore document for reimbursement first, compliance second, and clinical communication only distantly thereafter.

Time once spent examining patients, thinking through diagnoses, and explaining treatment is now devoted to documentation required for insurance payment. Ordering even a simple medication can require multiple clicks through billing-driven workflows. The cumulative effect is what many physicians describe as "click fatigue"—a professional environment in which the physician increasingly functions as a data-entry clerk inside a revenue system.

This transformation has profound consequences for professional identity. The physician is no longer an independent fiduciary working directly for a patient but a licensed participant inside a managed reimbursement structure. Clinical judgment operates within administrative boundaries defined by coding rules, prior authorization requirements, and reimbursement protocols.

Burnout and attrition follow not because physicians have become fragile, but because the structure of the work has changed. Earlier generations of physicians often practiced until they were physically unable to continue. By my 25th medical school reunion, nearly half of my classmates had already left clinical practice. These physicians were in their early fifties—years that should represent the professional apex of a medical career: experienced enough to exercise mature clinical judgment, yet young enough to adapt to new technologies and to mentor the next generation of physicians. Losing physicians at precisely this stage represents not merely an individual career change but a significant loss of institutional knowledge and leadership within the profession. The explanation is not cultural fragility. It is structural redesign.

When physicians no longer control the terms under which they practice, the profession is diminished—and patients ultimately pay the price.

C. The System: How Incentives Inflate Spending

The financial consequences of incentive inversion scale across the entire health system. Excess U.S. health spending approaches one trillion dollars annually, and the United States has roughly one million practicing physicians. This means that every year each physician makes thousands of routine clinical decisions that account for roughly one million dollars in excess medical spending.

The question is why. This occurs not because physicians intend to generate unnecessary costs, but because the incentives surrounding clinical decisions encourage additional spending while the normal consumer constraints on spending are absent. When patients are insulated from the cost of care—and when insurers and intermediaries function primarily as payment administrators rather than true purchasers—little within the system operates to restrain utilization.

Administrative infrastructure—billing departments, compliance teams, utilization review units, and intermediary functions—absorbs resources that do not directly deliver care. Nonclinical administrative costs account for roughly 30 percent of U.S. healthcare spending, far higher than in other high-income nations.

The United States now spends nearly one-fifth of its national income on healthcare, while most advanced economies spend roughly half that share. Despite this spending gap, health outcomes in the United States are typically worse than peer countries that spend substantially less.

At the system level, incentive inversion misallocates medical spending. The system is not organized around patient wellness but around billable categories. When reimbursement determines revenue, care is steered toward reimbursable procedures rather than toward the most effective forms of prevention or long-term health. The system readily pays for expensive interventions but not to support sustained weight-loss or lifestyle programs that could prevent those procedures in the first place. Site-of-service payment differentials further reward hospital delivery over lower-cost outpatient alternatives even when the clinical service is identical.

Mediated contracting also produces substantial price dispersion. Because reimbursement is negotiated privately between insurers and provider systems, identical services can command dramatically different prices across institutions and insurance networks. Research consistently finds wide variation in commercial prices for the same procedures, reflecting bargaining leverage rather than clinical complexity.

The cumulative result is persistent inflationary pressure. When the person receiving care does not negotiate price directly and reimbursement structures mediate payment, spending predictably expands. The system grows more expensive not primarily because Americans receive more effective care, but because its financing architecture rewards spending rather than restraint.

SYNTHESIS

These consequences are not independent failures. They are the predictable result of a system in which the person receiving care does not control the purchase and the physician does not control the terms of care. If that diagnosis is correct, the policy implication follows naturally: the financing structure must be realigned so that the person receiving care once again directs the purchase of care.

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[14] Shrank WH, Rogstad TL, Parekh N. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." JAMA 2019.

[15] Association of American Medical Colleges, 2023 Physician Workforce Data Report. Federation of State Medical Boards, U.S. Physician Census 2022.

[16] David Himmelstein et al., "Health Care Administrative Costs in the United States and Canada, 2017," Annals of Internal Medicine 174, no. 2 (2020): 134–142.

[17] Organisation for Economic Co-operation and Development, Health at a Glance 2023: OECD Indicators (Paris: OECD Publishing, 2023).

V. Structural Realignment: Restoring Insurance to Its Proper Function

Realigning American healthcare requires restoring the economic architecture that links clinical decision-making, purchasing authority, and insurance risk. Most contemporary health policy debates frame the problem around the institutions that receive payment: insurers, hospitals, government programs, or pharmaceutical manufacturers. Analysts argue over premiums, reimbursement rates, drug pricing, or federal spending levels. These discussions focus on who is charging too much or who should pay more of the bill. But that framing overlooks the operational starting point of the system.

Healthcare spending does not begin with insurers, hospitals, or government budgets. It begins with clinical decisions. Every dollar of medical spending begins with a physician order—a test is ordered, a patient is admitted, a consultation is requested, or a procedure is scheduled. Costs ultimately emerge from millions of routine decisions made inside a reimbursement architecture that rewards additional services. When the financing structure encourages more testing, admission, and intervention, the system reliably produces more of each. Misdiagnosing the source of spending leads policy debates toward solutions that regulate prices while leaving the decision architecture unchanged.

A. A Systems Framework for Healthcare Incentives

Understanding this distortion requires a different analytical framework. Traditional health-policy analysis focuses on actors within the system. Systems analysis instead examines the structure of incentives that governs their behavior. Rather than emphasizing the motives or conduct of individual participants, it examines the incentives and feedback loops embedded in the system itself. In systems thinking, outcomes tend to reflect the behaviors that the system's design rewards.

As Friedrich Hayek observed in The Use of Knowledge in Society, efficient economic decisions depend on knowledge dispersed among many individuals—knowledge that no central authority can fully aggregate. When purchasing authority is concentrated in institutional intermediaries, that dispersed knowledge is suppressed. Prices no longer reflect the preferences and circumstances of the individuals actually receiving care.

The same principle applies to healthcare. When patients cannot see prices and cannot direct purchases, the information that would normally guide resource allocation is lost. Administrative systems expand to substitute for the market signals that have been suppressed.

B. Restoring the Patient as Purchaser

Restoring purchasing authority to patients does not require eliminating insurance. It requires distinguishing between what insurance is designed to do—protect against catastrophic, unpredictable loss—and what it has been repurposed to do: finance routine, predictable consumption.

When patients purchase routine care directly, prices become visible. Competition can function. Providers must explain and justify costs. The administrative infrastructure built to manage mediated payment becomes less necessary. Physicians can once again negotiate directly with patients, and patients can once again evaluate cost and quality at the point of decision.

This does not mean patients bear unlimited financial risk. Catastrophic coverage remains essential. The distinction is between using insurance for its proper function—absorbing rare, devastating losses—and using it as a prepayment mechanism for predictable expenses.

C. Restoring the Physician as Fiduciary

Restoring the physician's role as a direct fiduciary for the patient requires reducing the administrative intermediation that currently governs clinical decisions. When physicians can once again set prices, explain them to patients, and allow patients to decide, the clinical and economic conversations reunite.

Direct primary care models, concierge medicine, and cash-pay practices illustrate what this looks like in practice. Physicians in these models typically spend more time with patients, document less for billing purposes, and report higher professional satisfaction. Patients in these models often pay less in total while receiving more attentive care. The administrative layer is removed, and the physician-patient relationship is restored.

D. Restoring Insurance to Its Proper Function

Insurance returns to its proper function when it covers what it was designed to cover: catastrophic, unpredictable events. A high-deductible catastrophic plan paired with a health savings account or direct-pay arrangement for routine care approximates this structure. The patient directs routine spending, prices are visible, and competition functions. Insurance absorbs the rare, devastating loss that individuals cannot absorb on their own.

This structure also restores actuarial integrity. When insurance covers only uncertain events, premiums can reflect actual risk rather than the cost of routine consumption. Administrative overhead falls. The insurer returns to its original function as a risk pool rather than a payment intermediary.

VI. Policy Reform: Statutory Corrections

The distortions described in this paper arise from identifiable statutory sources. Correcting them does not require dismantling existing institutions. It requires targeted amendments to the tax code that remove asymmetrical treatment between employer-sponsored and individually purchased insurance.

The core reform is straightforward: extend equivalent tax treatment to individuals purchasing their own insurance. The objective is not to eliminate employer-sponsored plans—employers may continue contributing to coverage, and workers may continue choosing employer plans. The objective is to remove the fiscal penalty imposed on Americans who choose to purchase coverage directly.

Several approaches achieve this result: extending the §106 exclusion to individually purchased coverage regardless of purchase channel, or capping the existing exclusion while providing equivalent treatment for individual purchases. Each approach restores symmetry while allowing existing coverage arrangements, employer contributions, and regulatory structures to remain in place. The objective is not to eliminate employer-sponsored insurance but to remove the fiscal penalty imposed on Americans who choose to purchase coverage directly.

A. Current Statutory Architecture

American health insurance operates within overlapping state and federal law built over decades. Any serious reform must begin by acknowledging that structure. Nothing in this proposal mandates a change in coverage design. It removes a fiscal distortion within the existing framework.

Insurance regulation begins at the state level. States license insurers, enforce solvency standards, require rate filings, and impose consumer protection rules. Insurers must meet capital requirements and comply with state benefit mandates. Those rules determine what products may legally be sold. Federal law sits on top of that structure.

The Internal Revenue Code shapes purchasing behavior more than any other statute. I.R.C. §106 permits workers to receive compensation in the form of tax-free health insurance, bypassing income and payroll taxes for employees and payroll taxes for employers. Individuals purchasing insurance directly, by contrast, must generally do so with after-tax income.

This asymmetry creates a substantial structural bias toward employer-mediated coverage. For many workers the tax advantage makes employer-provided insurance roughly 30–40 percent cheaper than an equivalent policy purchased independently. Over time, this subsidy encouraged employers to offer plans that covered routine medical expenses—often in place of higher wages—which in turn promoted the use of insurance for routine medical spending rather than catastrophic risk. It also shifted purchasing authority from individuals to employers.

Section 106's exclusion of employer-sponsored premiums from employee taxable income creates the core tax asymmetry favoring employer-mediated coverage. A second statutory mechanism reinforces this structure. Section 4980H imposes penalties on large employers that fail to offer qualifying health coverage to employees. The tax code therefore does not merely favor employer-sponsored insurance—it also pressures employers to provide it. Together these statutes regulate eligibility and continuity while leaving employer-sponsored insurance structurally privileged.

ERISA further entrenched employer-based coverage by establishing federal governance over employee benefit plans and preempting many state laws for self-funded arrangements. Later reforms layered additional regulation onto this structure without altering the underlying tax preference. The Affordable Care Act introduced exchanges, essential health benefit requirements, rating rules, and risk adjustment mechanisms. Other federal statutes—including HIPAA, MHPAEA, and COBRA—govern portability, parity, and continuation of coverage. Together these laws regulate the operation of coverage but leave the underlying tax asymmetry intact.

This statutory structure remains entirely in place. What changes is not the regulatory framework, but the tax asymmetry that distorts purchasing authority. Individuals and employers satisfied with their existing coverage arrangements would be able to retain them.

B. Structural Corrections

The distortions identified in this paper arise primarily from two statutory sources: asymmetrical tax treatment and employer-centered coercion within the Internal Revenue Code. Correcting them requires targeted amendments rather than structural dismantling of existing programs. Medicaid, ERISA governance, exchanges, and existing regulatory protections remain intact. The reforms described below equalize incentives; they do not eliminate institutions.

1. Restore Tax Neutrality

Section 106 excludes employer-sponsored premiums from employee taxable income. No equivalent treatment exists for most individually purchased coverage. That asymmetry privileges mediated payment and entrenches employer control. Tax neutrality would extend equivalent tax treatment to individuals purchasing their own insurance. Employers could continue deducting compensation expenses and contributing to coverage, but individuals would receive parallel treatment for premiums they purchase directly. The objective is not to eliminate employer-sponsored plans but to remove the fiscal penalty imposed on Americans who choose to purchase coverage independently.

2. Decouple Tax Preference from ACA Participation

Under current law, favorable tax treatment is effectively tied to participation in ACA-defined product structures. This linkage narrows product diversity and limits actuarial flexibility. Reform would extend equal tax treatment to any state-regulated insurance contract that satisfies solvency and disclosure standards. Exchanges may continue operating, but they would no longer serve as the exclusive gateway to tax-favored status.

3. Neutralize the Employer Mandate Penalty

Section 4980H imposes penalties on employers that fail to offer qualifying coverage. Although the individual mandate penalty was reduced to zero in 2017, the employer mandate remains. Setting the §4980H penalty to zero would eliminate statutory coercion while allowing voluntary employer participation in group coverage to continue. Employers that find group plans efficient may maintain them; others may adopt defined contributions, stipends, or portable arrangements.

C. Transitional Stability and Institutional Continuity

Realigning incentives does not require disruption. It requires removing asymmetrical coercion. Employer-sponsored plans may continue—without exclusive tax preference and without statutory compulsion. Reform means tax symmetry and restored purchasing authority, not repeal.

Employers may continue contributing to healthcare expenses. The reform changes who chooses the coverage, not whether employers can help pay for it. Stipends, ICHRAs, portable arrangements, and voluntary group plans all remain available.

Insurance markets already operate across diverse product types. Under tax neutrality, catastrophic-focused plans would likely expand, high-deductible structures would preserve price sensitivity, and routine care would migrate toward transparent pricing. Competition would shift toward actuarial integrity and consumer value rather than network breadth alone. Because exchanges, Medicaid, and ERISA remain intact, institutional continuity is preserved. Individuals and employers satisfied with current arrangements may retain them.

Incentives reshape behavior gradually. As purchasing authority shifts toward individuals, price transparency becomes economically necessary and administrative layers face competitive pressure. Employers increasingly treat healthcare as compensation rather than governance, and bilateral physician–patient contracting re-emerges where economically rational.

Emergency medical stabilization remains a civilizational obligation. The distinction between catastrophic risk, routine consumption, and public stabilization clarifies roles without destabilizing institutions.

By restoring symmetry in the tax code, reform permits gradual evolution within a modern regulatory state. The institutional structure remains intact. Only the distortion is removed.

D. Strategic Framing and Coalition Alignment

Structural reform succeeds only when it is clearly understood. The core message is simple: the tax code penalizes Americans for buying their own health insurance. Employer-mediated coverage receives preferential tax treatment; direct purchase does not. This proposal eliminates no options. It restores symmetry and allows Americans to choose.

The natural coalition begins with workers. In an era of remote and mobile employment, independent contractors, freelancers, gig workers, young professionals, and employees seeking portability are disadvantaged by employment-tethered coverage. Tying insurance to a job constrains mobility and discourages entrepreneurship. Tax neutrality reframes coverage as portable personal property rather than employer-controlled infrastructure.

Small businesses face similar disadvantages due to administrative scale. Allowing defined-contribution models and removing coercive mandates reduces administrative burden and narrows competitive disparities between large and small employers. Large employers may also benefit from a system in which healthcare becomes a predictable compensation expense rather than an administratively complex liability.

Equal tax treatment also restores wage transparency. Workers already pay for premiums—they simply do so invisibly. When the tax code no longer obscures that reality, total compensation becomes clearer and more negotiable.

The emergence of Individual Coverage Health Reimbursement Arrangements (ICHRAs) illustrates this pressure directly. Employers are already experimenting with ways to move purchasing authority back to individuals even though the tax code continues to subsidize employer-controlled coverage.

Family choice reinforces the stability of this reform. Nothing here repeals the ACA or eliminates exchanges. It removes exclusive tax privilege. Families may continue selecting standardized plans, or they may choose alternatives that better reflect their risk tolerance and financial priorities. This is reform without repeal—equalization without dismantling.

Opposition should be anticipated. Benefits administrators and insurance intermediaries benefit from the mediated model. Portions of the insurance and hospital sectors benefit from price opacity. Administrative incumbents benefit from regulatory complexity. Some progressive advocates favor centralized standardization and may resist decentralization of purchasing authority.

The coalition logic is straightforward: restore symmetry, restore portability, restore transparency. Equal tax treatment is not radical—it is corrective. When Americans are no longer penalized for purchasing their own coverage, markets—not statutory favoritism—will determine which models endure. This proposal does not rewind the system to a prior era. It removes a tax distortion embedded since World War II and restores purchasing symmetry within the existing regulatory state.

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[25] The Affordable Care Act originally paired the employer mandate with an individual coverage mandate under I.R.C. §5000A. Congress reduced the individual mandate penalty to zero in 2017, leaving the employer mandate and the underlying tax preference for employer-sponsored coverage largely intact.

VII. Conclusion

American health policy analysis typically treats high healthcare costs as a problem of prices, spending levels, or the conduct of particular institutions. This paper argues that the deeper problem lies elsewhere: the structure of incentives embedded in the financing system. When purchasing authority separates from the person receiving care, the normal disciplines of price awareness and clinical accountability weaken.

Realigning the system therefore does not require dismantling existing programs or institutions. It requires correcting a small number of statutory asymmetries—principally the tax preference for employer-sponsored insurance—that separate purchasing authority from the patient. Restoring symmetry in the tax code allows insurance to return to its proper function: protection against catastrophic risk rather than routine consumption.

Most reform proposals attempt to regulate prices or expand coverage while leaving the decision architecture unchanged. This analysis approaches the problem differently. It examines how incentives are structured within the system and how those incentives shape behavior across millions of clinical encounters.

Healthcare spending ultimately emerges from clinical decisions. When those decisions occur within a financing architecture that rewards expansion, the system predictably produces more spending. When purchasing authority, price awareness, and clinical judgment are realigned, the system stabilizes.

The American healthcare system behaves irrationally because it is structured irrationally. Systems behave according to the incentives embedded within them. When purchasing authority is separated from the person receiving care, when insurance finances routine consumption rather than catastrophic risk, and when reimbursement architectures reward expansion, the system will predictably generate ever-greater spending.

Eliminating the tax asymmetry that favors employer-sponsored insurance, removing statutory barriers that prevent individuals from choosing catastrophic coverage, and returning purchasing authority to patients would restore coherence to healthcare financing.

> Systems behave according to their incentives. When incentives are rational, systems behave rationally.