THE GREAT AMERICAN HEALTH CARE SCAM

HOW POLITICIANS CREATED A SYSTEM THAT WASTED TRILLIONS AND TRAPPED YOU IN IT

The Great American Health Insurance Scam

Chapter 1: The Myth of the "Benefit" – Employees Pay the Price

Summary: Employer-sponsored health insurance (ESI) is often portrayed as a generous gift or perk from employers. This opening chapter debunks that notion. What's labeled a "benefit" is in fact financed by workers themselves through lower wages. By definition, a true *benefit* is something provided by an employer **in addition to** your wages. Yet with ESI, employers simply reallocate part of your compensation to pay insurance premiums instead of adding extra on top of your salary. Economists widely agree that employees ultimately bear **100%** of the cost of employer health insurance in the form of reduced take-home pay. In other words, the money for your health plan comes out of *your* paycheck – it's a hidden wage deduction. This chapter explains how that hidden cost originated and why companies call health coverage a "benefit" to begin with. We'll use a simple example to illustrate: if your employer weren't spending, say, $5,000 a year on health premiums on your behalf, that $5,000 could instead be part of your salary. By chapter's end, it will be clear that far from being a generous freebie, ESI is a sleight-of-hand trick – you **foot the bill** through foregone wages, even as it's packaged to make you feel your employer is doing you a favor.

The Meaning of "Benefit" vs. the Reality of ESI

Let's start with the basic definition of a "benefit." According to Merriam-Webster, an employee benefit is "a service (such as health insurance) or right (as to take vacation time) provided by an employer **in addition to** wages or salary". In plain terms, a benefit should be an *extra*, something given on top of your regular pay. If your boss gives you a $500 holiday bonus **in addition** to your normal paycheck, that bonus is a true benefit – it's extra money that you wouldn't otherwise get. The myth with employer health insurance is that it's an extra like that, a generous add-on. But in reality, it's not extra at all. It's part of your **total compensation** package, funded by the value of your work just like your salary. Calling it a "benefit" creates the illusion that your employer is doing you a generous service, when in fact **you are paying for it** through compensation trade-offs.

Think of it this way: If an employer could somehow stop providing health insurance but keep everything else the same, could they just pocket the savings? In a competitive job market, probably not – they would likely have to offer higher wages to attract and retain employees. That's because the money used for health premiums was effectively *your money* to begin with,

allocated to you as part of your pay package. Calling the insurance a benefit is a bit like a friend saying, "I bought you a gift with your own money." For example, imagine a friend owes you $100 for helping them move. When paying you back, they hand you $80 in cash and a $20 gift card, proudly calling the gift card a special **"benefit"** for your help. You wouldn't be fooled – you know that $20 simply came out of the $100 you were owed. The total value you received is still $100, not $120. Employer health plans work the same way: the company's contribution to your insurance premium comes out of the total amount they're willing to pay you for your work. It's not an extra reward; it's a **slice of your own earnings** being routed to an insurance company on your behalf.

Most people don't realize this. In fact, studies and policy analyses have found that **few workers understand** how much their employer spends on health insurance or that those costs ultimately come out of their wages. It's easy to see why there's confusion – pay stubs show deductions for the portion of premium you pay, but the much larger employer portion is usually invisible in your take-home pay. It feels like the company is footing that big bill. But behind the scenes, your employer is balancing a labor budget for your position. If health insurance costs go up, something else (usually wage growth) gives way. As one report bluntly stated, "the nearly $1 trillion that employers spend on health benefits each year comes from workers, not from employers. Employers finance spending on health benefits by reducing other forms of employee compensation, typically wages". In short, **you** pay, just through a less visible mechanism. The next sections will break down how this works in practice.

Total Compensation: One Big Pie (And You Only Get the Slices)

To understand why employees, bear the cost of ESI, we need to look at the concept of **total compensation**. When a company hires you, they think in terms of the total value of your compensation – this includes your salary **plus** any benefits (health insurance, retirement contributions, paid time off, etc.). You can picture your total compensation as a pie: one slice is your direct wage (cash salary), and the other slices are the various benefits. The key insight is that the overall size of the pie is **fixed** by the employer's budget for your role. The employer isn't going to keep enlarging the pie for every benefit; instead, they reallocate slices.

Think of it from the employer's perspective. Say a company determines that a particular job is worth $60,000 a year in total compensation based on the role's responsibilities and market rates. That $60,000 is the **price** they are willing to pay for that labor. How they split that $60,000 can vary:

- **All Cash, No Benefits:** The company could offer $60,000 straight as salary and no health insurance. You get all of it in your paycheck (ignoring taxes).
- **Cash + Health Benefit:** Alternatively, the company could offer $55,000 in salary and also provide a health insurance plan that costs them $5,000 for the year. You still "get" $60,000 total – but it's $55k in cash and $5k going to an insurance company for your benefit.

Either way, the employer's total outlay is $60,000. In the second scenario, that $5,000 insurance premium is coming out of the compensation pie. It's money **you earned** through your labor, which the employer is using on your behalf for insurance. The result? Your paycheck is $5,000 lower than it could have been if no insurance was provided, because part of your compensation was diverted to health coverage. In this simplified example, you effectively **paid** $5,000 for your health insurance – it just never showed up in your pay stub as wages to begin with.

This trade-off is how benefits are funded. Economists describe it as a *compensation bundle* or package. There's a **fixed pool** of compensation dollars for each job. If something is added to that package (like a new benefit), something else (cash wages) will be adjusted downward so the total stays in line with the value of the job. Far from being a gift outside of what your work earns, the health plan is **purchased with your work just like your salary is**.

Let's reinforce this with a relatable scenario: suppose you are choosing between two job offers. Job A offers a $70,000 salary but no health benefits. Job B offers a $60,000 salary and includes health insurance. At first glance, Job B's benefits sound attractive – many people instinctively value the insurance as a "perk." But look closer at the math. If the health insurance plan is worth $10,000 per year in premiums, then Job B's total compensation is roughly $70,000 ($60k salary + $10k insurance). Job A's total compensation is $70,000 all in cash. They are essentially equal in total compensation value. Job B is not truly giving you more; it's simply giving you part of your compensation in a different form. In fact, **Job A might feel better in your wallet** because you see all $70,000 and could buy insurance of your choice. Job B's approach funnels part of your $70k package directly to an insurer. The crucial point is that **either way, you ultimately earn and pay for whatever insurance you get**. If a company tried to offer a low salary *and* no benefits without raising the total pay, they would have a hard time finding workers – because workers implicitly expect that if benefits are missing, the salary should be higher to compensate. This dynamic shows that benefits are part of the market compensation for labor, not a bonus from an employer's charity.

The Hidden Trade-Off: Lower Wages for Health Insurance

The relationship between employer insurance and wages isn't just theoretical – it's supported by substantial economic research. Economists have a term for figuring out who *really* pays for something: **incidence**. Numerous studies over decades have examined the incidence of employer-provided benefits, and a consistent finding is that the cost lands on the employee. In the case of health insurance, "workers' pay for their health insurance costs through reduced wages" according to economic research summarized by the Federal Reserve. In plain English, every dollar your employer spends on your health coverage is effectively a dollar less that they pay you in cash. Over the long run, as health insurance costs have risen, this trade-off has been a factor in why wage growth has lagged – a chunk of what could have been raises is instead going to insurance premiums. One analysis from the Center for American Progress put it succinctly: as premiums rise, they consume a growing share of total compensation, **cutting into employees' take-home pay**.

It's important to clarify that this doesn't mean your boss is maliciously scheming to cut your pay. Often, employers themselves may think they are contributing generously to employees' well-

being by offering benefits. But the labor market forces, and business budgeting work out such that those contributions are coming out of the overall pay budget for employees. Think of a seesaw: on one end is your wages, on the other is your benefits. The total weight on the see-saw corresponds to your total compensation. If the weight on the "benefits" side (like health premiums) gets heavier, the weight on the "wages" side goes down to keep balance. **Your employer's total spend on you is the fulcrum – it stays roughly constant.**

Another way to view it is through your employer's accounting. Companies generally treat benefit costs as part of employee compensation expenses. For example, if health insurance premiums increase by 10% one year, the company's cost of employing each person rises. In response, they might give smaller raises or none at all, effectively letting the extra benefit cost **replace** what could have been a pay increase. This isn't personal or vindictive; it's just how the compensation math works out. Over time, employees may wonder "why isn't my paycheck growing?" – one little-discussed reason is that a significant portion of compensation growth has been going into benefits, especially health insurance, rather than into salaries. In other words, you've been getting raises – but they've been absorbed by the escalating cost of your health plan.

To see the hidden trade-off in action, look at the breakdown of premium payments. Often, you'll hear something like, "The employer pays 75% of the health insurance premium, and the employee pays 25%." On the surface, it sounds like the employer is covering the bulk of the cost. For instance, in 2021 the average employer-sponsored family health plan premium was about $22,000. Employers on average paid roughly $16,000 of that, while employees paid about $6,000 directly through paycheck deductions. Many workers interpret that as "my company gave me $16k of value for free, and I only paid $6k." However, from the economic viewpoint we've described, that $16,000 came from the **same pool of money** that could have otherwise been your wages. If that $16k weren't spent on insurance, it could theoretically be available for other compensation (or the company's savings, but in a competitive labor market, employers generally have to return it to employees either via wages or some other benefit to remain competitive). The $6,000 you paid is just the visible part of your contribution; the other $16,000 was **paid by you indirectly** via a lower salary than you might have had if no insurance were provided. Thus, **100% of the $22k premium was ultimately paid by you**, not 25%. The split between "employer share" and "employee share" is mostly about **who writes the check**, not who shoulders the economic burden.

Economists Agree: Workers Bear the Full Cost

This idea that workers pay for benefits in the form of lower wages is not a fringe theory – it's the mainstream view among labor economists. As noted earlier, a Federal Reserve study stated that economists *"generally agree"* on this point. The consensus has been supported by empirical research. For example, studies have found that when employers face higher insurance costs (due to things like health care inflation or new mandates), they respond by slowing wage growth or even reducing wages to offset those costs. Conversely, if health costs were to go down or if an employer drops an insurance benefit, one would expect wages to eventually rise by a comparable amount (assuming a competitive market for workers). The labor market essentially treats benefits as just another form of compensation.

It might be surprising to hear that *all* of the cost is borne by workers. One might think, "Surely employers share some of the cost, since they could just pay less total compensation?" The key is that in equilibrium, the labor market sets compensation based on the value of the work and the supply/demand for that type of labor. If one employer tried to skimp by offering a lower total compensation (no insurance and no equivalent raise in pay), workers would likely go to another employer who offers a better package. So, employers generally don't get away with spending less on you *in total* just because they offer insurance; they simply **allocate** that spending differently. Over the entire economy, the prevalence of health benefits means that baseline wages have adjusted downward from what they would be in a hypothetical world with no employer insurance. Put another way, decades ago as health benefits became common, explicit wages grew more slowly than they otherwise would have – locking in the trade-off. One policy analysis by the Cato Institute explains it succinctly: "The nearly $1 trillion that employers spend on health benefits each year comes from workers, not from employers". Employers pay for health insurance by **reducing other forms of compensation** (mostly wages). Economists sometimes quantify this by saying that for every additional dollar an employer must spend on health insurance, workers effectively give up a dollar in wages. It's a one-to-one trade in the long run.

There are plenty of real-world illustrations of this principle. Consider the scenario when a new mandate or cost hits employers – say, a required increase in the minimum level of health coverage they must provide. If a law or market condition increases employer insurance costs, studies show new hires often get lower starting salaries than they otherwise would, or raises for existing workers are smaller that year. On the flip side, if an employer were to drop health benefits entirely, we would expect that they'd need to offer higher salaries to attract employees (or those employees would leave for jobs that do offer health benefits or higher pay). In fact, surveys suggest many workers *would* prefer higher pay in lieu of employer benefits in some cases. For instance, one survey cited in a policy report found that among employers who don't offer health insurance, 74% reported their employees would prefer an extra $2 per hour in wages over health benefits. That $2 per hour roughly equates to what the employer would have spent on insurance. This again highlights that benefits are part of the compensation equation – workers see them in comparison to cash.

Why Do Employers Call It a "Benefit"? (Psychology and Origins)

If employer health insurance is essentially funded by employees, why do companies insist on calling it a **benefit** and touting it as a perk? There are a few reasons – some historical, some psychological, and some practical.

1. Attracting and Retaining Talent: Offering health insurance *is* a valuable part of a compensation package because employees need and want health coverage. Especially in the United States, getting insurance through an employer is often cheaper and easier than buying it on the individual market (thanks in part to tax advantages and group rates). Employers know that a good health plan helps attract employees and reduce turnover. In fact, surveys show health insurance is one of the main benefits workers look for when job hunting. So from a recruitment standpoint, employers *promote* their health insurance offering as a benefit to make the job more

appealing. It's a bit of marketing – they highlight that feature of the compensation package to differentiate themselves. The terminology of calling it a "benefit" reinforces the idea that you're getting something special.

2. Tax Advantages (Government Incentives): There's a financial reason rooted in policy: employer-paid health premiums are generally **not taxed** as income to the employee. If your employer pays $5,000 for your insurance, you don't pay income or payroll taxes on that $5,000, unlike regular wages. This tax break dates back to World War II and the post-war era when employer health benefits first became widespread. During WWII, the government-imposed wage freezes to curb inflation, but in 1943 the War Labor Board ruled that contributions to insurance and pension plans didn't count as wages, allowing companies to offer health benefits to attract scarce workers despite the wage caps. This was effectively a loophole to compete for talent – and it worked: by war's end, coverage had tripled as many employers added health plans. The practice stuck, and in 1954 the IRS officially codified that employer-paid health insurance premiums are tax-exempt for employees. The outcome is that both employers and employees have had a mutual incentive to structure some compensation as health benefits – it saves on taxes for both parties (employers can often deduct the expense, and employees don't count it as taxable income). Because of this **tax exclusion**, a dollar spent on health insurance is worth more to an employee than a dollar of wages (which would be taxed). So, employers frame it as a benefit they provide, emphasizing how they are taking care of you with health coverage – while also implicitly understanding that it's an efficient way to compensate you due to tax policy. Importantly, this tax benefit doesn't change the fact that the premium is still coming out of your total compensation – it just means the government is subsidizing that form of compensation. One analyst described the situation as coercing workers into letting the employer control that part of their pay for the tax advantage, noting that many workers aren't fully aware this money is part of their earnings.

3. Psychological Framing – The Gift Illusion: Humans tend to perceive something given to them differently than something they pay for themselves. Employers and society at large have long taken advantage of this quirk. By labeling health insurance as an employer-provided benefit, it *feels* like a gift or a favor. It's presented as, "We care about our employees, so we give them health coverage." This framing can engender loyalty or appreciation, much like a gift from a friend or family member might. It also softens the blow of what would otherwise be just a reduction in salary. Imagine if instead of saying "we offer great health benefits," an employer said, "we will reduce your pay by several thousand dollars to buy you health insurance." The latter phrasing is actually more accurate, but it's also a lot less appealing! By using the language of benefits, the true cost is obscured. Many employees never actively think about the connection between the cost of their health plan and their wages – after all, they don't see that cost directly. This lack of transparency perpetuates the myth that the employer is giving something extra. In behavioral economics, this is related to the concept of the **money illusion** and indirect compensation – people are often bad at valuing non-cash benefits relative to cash. Employers simply take advantage of that: they know employees will value the health insurance highly (because it is valuable coverage), and by bundling it as a benefit, it feels like a plus rather than part of a zero-sum trade.

In summary, employers call it a benefit both because it *is* a valued part of compensation (important for attracting you) and because the wording and presentation lead you to feel taken care of, rather than realizing you paid for your own healthcare with foregone wages. The history of how this all started – with WWII wage freezes and subsequent tax preferences – set the stage for employer insurance to be the norm and to always be spoken of as a benefit. This language has become so standard that even employees refer to it as part of their "benefits package," seldom pausing to question that phrasing.

The Reality: You Pay the Price

It's time to dispel the illusion once and for all: employer-sponsored insurance is **not a gift** from your company – it's part of your earned compensation. Your labor is generating the funds that pay for your health plan. The employer is essentially an intermediary, taking a portion of what would have been your gross pay and using it to buy insurance for you. In a very real sense, you **wrote the check**, even though it's the company's name on the check to the insurance carrier.

This arrangement can be thought of as a sleight-of-hand. On the one hand, your employer offers to pay your hefty insurance premiums; with the other hand, they adjust your wage offers and raises to cover that cost. You end up feeling grateful for the insurance support, without noticing the corresponding hit to your paycheck. As one Federal Reserve economist noted decades ago, what employers spend on health benefits "passes on" to workers in the form of lower wages. In more direct terms, every dollar your boss spends on your health insurance is a dollar less in your paycheck. It may not be labeled as such on your pay stub, but it's a **real cost** to you. Indeed, if health benefits vanished and all else stayed equal, economic theory and evidence suggest that over time workers would demand and receive higher pay to make up the difference. The fact that this doesn't happen (because benefits remain prevalent) is exactly why we say workers are paying for their benefits – they have already traded off higher pay for those benefits.

None of this is to say health insurance isn't valuable or that employers are evil for structuring pay this way. Health coverage is extremely important to most people, and having it provided through work can be convenient and, due to tax breaks, financially sensible in our current system. The goal here is simply to **unmask the true payer**. When you hear "this company pays $X toward your health insurance," translate that in your mind to "this company is allocating $X of my earnings to health insurance." When you see the word "benefit," remember its literal definition – something extra on top of wages – and recognize that employer health insurance doesn't actually meet that definition in a financial sense. It's not extra; it's part of the whole.

So, the myth of ESI as a free perk should be laid to rest. The truth is empowering: if employees collectively understand that they are footing the bill, they might demand better value for those dollars – whether in the form of more affordable health plans, higher wages, or a say in how their compensation is used. In later chapters, we will explore the implications of this reality, including how this hidden cost impacts wage growth and what alternatives might give workers more control. But the first step is awareness. The next time someone refers to health insurance as a "benefit" from an employer, you'll know to respond: *"It's part of my compensation, and I'm ultimately paying for it."* In fact, you've been paying all along.

Key Takeaways

- **“Benefits” are supposed to be extras:** By definition, an employee benefit (like health insurance) is something provided *in addition to* your wages. However, in the case of employer-sponsored insurance, it’s not truly an add-on – it’s funded out of your own compensation.
- **You bear the full cost via lower wages:** Workers pay the *entire* cost of employer health plans in the form of reduced take-home pay. Decades of economic research confirm that for every dollar an employer spends on health insurance, wages are lower by a dollar. In essence, you are paying 100% of the premium, just indirectly.
- **ESI as a “gift” is a myth:** The idea that your employer is generously giving you health coverage is an illusion. In reality, it’s a portion of your earned pay being channeled into insurance. Far from a free perk, that “benefit” is one you’ve been financing all along through foregone wages.

Chapter 2: What Insurance Should Be: The Simple Power of Risk Pooling

Insurance Is Risk Transfer: At its core, **insurance is a simple but powerful concept – the transfer of risk from an individual to a larger group**. Whether it's life insurance, home insurance, or auto insurance, the principle is the same: you pay a small, predictable amount (a premium) to an insurer, and in return the insurer promises to cover the big, unpredictable costs that might arise from rare events. In other words, **you trade uncertainty for certainty**. You accept the certain cost of the premium so that you won't face a potentially catastrophic cost alone. This is risk pooling and transference in action – **spreading the financial risk of the unlucky few across a broad pool of people.** The purpose is protection: **to shield individuals from financial ruin due to accidents, disasters, or illnesses by sharing the burden collectively**.

How Insurance Works (Life, Home, Auto): To appreciate what insurance *should* be, consider how it works in other areas of life. **Life insurance** doesn't pay your grocery bills or day-to-day expenses; it provides a payout to your family *only if* a rare event (your untimely death) occurs. **Auto insurance** doesn't cover oil changes or fuel; it helps repair or replace your car if you crash, or covers liability if you injure someone – again, low-probability but high-cost events. **Homeowners insurance** won't pay to mow your lawn or fix a leaky faucet; it compensates you if a fire burns down your house or a storm causes major damage. In each case, the insurance is **focused on unforeseen, significant losses**, not routine costs. We pay those premiums hoping never to "use" the coverage in a major way – but we sleep easier knowing it's there if disaster strikes.

The Insurer's Role: In a proper insurance model, an insurance company functions as a **professional risk-taker**. The insurer is willing to accept the risk of large payouts for those few who face catastrophes, in exchange for collecting premiums from the many. They use statistics and actuarial science to set those premiums at a level that covers the expected claims and includes a margin for their operating costs and profit. In a well-functioning insurance market, **insurers profit by managing risk wisely** – minimizing unnecessary claims, encouraging safety or preventive measures, and negotiating fair prices for services – all to ensure that they can cover claims while keeping premiums competitive. Ideally, **the incentives align so that preventing a loss (or reducing its cost) benefits both the customer and the insurer**. For example, car insurers give discounts for safe driving or anti-theft devices – fewer accidents and thefts mean fewer claims, which is good for the company and customers alike.

Insurance vs. Prepaid Service Plans: It's crucial to highlight **what insurance is *not***. Insurance is not merely a payment mechanism for **expected routine expenses** – that would be more like a subscription or prepaid service plan. Think about it this way: if your auto insurer paid for your gas, oil changes, and new tires, what would happen? First, your car insurance premium would skyrocket to cover all those guaranteed, frequent costs (plus administrative overhead). Second, you as a driver might care a lot less about prices – who shops for the cheapest gas when someone else pays? Third, providers of those services (gas stations, mechanics) could start raising prices,

since the consumer isn't sensitive to cost. The whole arrangement would be absurd. **Thankfully, car insurance only covers the *big* stuff (accidents, liability) and not "everyday stuff, like gas and oil changes".** As one doctor quipped in an analogy: *your life insurance doesn't send you money for organic groceries, so why should health insurance be any different?* The same holds for homeowners insurance – it doesn't foot the bill for a new coat of paint or routine repairs, and if it did, the cost of a home insurance policy would be unaffordable. **True insurance is about rare *risks*, not regular *maintenance*.**

The True Purpose of Insurance: Protection from Catastrophe

Protection and Peace of Mind: The fundamental purpose of insurance is **to protect you from financial catastrophe**, not to cover every bill. When structured correctly, insurance provides **peace of mind**. You know that if an unpredictable disaster strikes – a major car wreck, a house fire, a serious illness – you won't be alone to face the bills. The **risk has been transferred**. Many people pool their resources (their premiums) so that the unlucky few who experience those disasters can be made financially whole. In this way, **no single family has to bear the full brunt of a costly misfortune**. This social utility of insurance is profound: it prevents bankruptcies, safeguards livelihoods, and allows people to take productive risks in life (buying a home, driving a car, starting a business) without fear that one stroke of bad luck will ruin them.

Efficiency Through Pooling: When insurance sticks to its core purpose, it can be efficient. Most people in the pool will not suffer a disaster in a given year – their premiums go to cover the few who do. Because catastrophic events are relatively rare, **the average premium can be affordable compared to the enormous payout one might otherwise face**. For example, only a tiny percentage of homes burn down each year. If thousands of homeowners each chip in a small amount annually, the one homeowner whose house does burn down can be fully compensated from that pool. Everyone trades the *possibility* of losing (hundreds of thousands of dollars in a fire) for the *certainty* of losing a few hundred dollars (the premium). This trade-off works because **not everyone will have a disaster at once**, and pooling smooths out the risk. In a healthy insurance scenario, **the insurer's overhead and profit are modest add-ons** to this pooled cost – ideally, just enough to run the business and reward taking on the risk, but not so much as to negate the value of pooling.

Aligning Incentives: In an ideal insurance model, the incentives encourage **prevention losses and controlling costs**. If claims are lower than expected (because, say, drivers drove more safely or homes were built to be disaster-resistant), the insurer may profit more in the short run – but market competition should then drive premiums down or force insurers to offer refunds or improved coverage to attract customers. Likewise, policyholders have an incentive not to file frivolous claims or engage in risky behavior, because they might face deductibles, premium hikes, or even cancellation. There is a healthy tension: the insurer wants to avoid paying unnecessary claims, and the insured doesn't want to suffer a loss (or higher costs) either. When insurance is confined to rare events, this dynamic helps keep the system sustainable and affordable.

How Health Insurance Was Meant to Work

Originally, Catastrophic Protection: Health insurance started out much like other insurances – as **protection against unpredictable, large expenses**. In the early days (mid-20th century), health insurance was often called "hospital insurance." It was designed to cover the kind of big medical bills that could bankrupt a family – a major surgery, a complicated childbirth, a serious illness requiring hospitalization. Routine doctor visits or small expenses were generally paid out-of-pocket, much like you paying for your own oil changes or home upkeep. The idea was that **if everyone chips in a little, no one will be financially crushed by a medical catastrophe**. This model treats insurance as a true safety net: it's there for dire situations, not for a sore throat or a yearly check-up.

The Expansion into Routine Costs: Over time, however, health insurance began to morph. It didn't stay focused on rare catastrophes; it started **covering more and more routine and expected services** – annual check-ups, blood tests, prescriptions, screenings, even minor outpatient treatments that many people need regularly. In insurance terminology, it shifted from being *pure insurance* (covering only low-probability, high-cost events) toward a **hybrid of insurance + prepayment**, where even high-probability, low-cost events were included. Imagine if your car insurance paid for every tune-up and tank of gas – that's essentially what happened with health coverage. In fact, the Institute of Medicine noted that health insurance in the U.S. has **"developed as a mechanism for financing or pre-paying a variety of health care benefits, including routine preventive services, whose use is neither rare nor unexpected."** It still **pools risk for the big expenses** – indeed, a small portion of patients account for the majority of health costs – *but* it also increasingly pays for the common, expected expenses of nearly everyone.

Why Covering Everything Is a Problem: At first glance, having insurance cover *everything* sounds like a great deal – who wouldn't want every doctor visit or prescription copay taken care of? The problem is, when insurance is used this way, **it no longer operates like true insurance and loses its efficiency and price-control mechanisms**. Instead, it starts to resemble a **"glorified bill-paying service"** rather than a risk shield. Several distortions occur:

- **Skyrocketing Premiums:** If an insurance plan pays for routine, expected services for everyone, the cost of those services (plus insurer overhead) gets rolled into the premium. Premiums climb dramatically because you're essentially pre-paying all your routine care through the insurer **(with added administrative costs)** instead of paying directly to providers. It's like an all-you-can-eat buffet: you pay more up front, whether you actually use a lot or not.
- **Reduced Cost Awareness:** When people aren't paying at point of service, they become less sensitive to prices. With insurance picking up the tab (or appearing to), patients might opt for the more expensive drug, or run extra tests "just to be safe," or not shop around for a better deal. This **moral hazard** – the tendency to use more when someone else pays – leads to higher overall utilization of healthcare services.
- **Providers Raising Charges:** Knowing that an insurance company is footing the bill (often after complex negotiations), hospitals and clinics have tended to set higher list prices. There's less pressure to keep prices transparent or competitive to individual

patients. The costs balloon, which then circles back into even higher premiums. It's a vicious cycle of medical inflation.

- **Administrative Bloat:** Every little charge – every doctor's visit, bandage, or lab test – now generates paperwork, claims processing, and sometimes prior authorizations or billing disputes. The involvement of insurance in every transaction adds **significant administrative overhead** to the healthcare system. It's like hiring an army of middlemen to pay your grocery bill; unnecessary for small purchases, and very costly at scale.
- **Diluted Incentives for Prevention:** Paradoxically, when insurers cover everything, their incentive to help avoid claims can weaken. If they can simply pass costs into higher premiums, there is less immediate push to ensure efficiency. In a traditional insurance mindset, avoiding a house fire is clearly beneficial to the insurer and homeowner; in a system where every minor health expense is reimbursed, distinguishing necessary from unnecessary care becomes harder, and insurers may focus more on managing expenses (through complex rules) rather than preventing them outright.

In summary, as health insurance broadened to cover routine costs, it **no longer resembled insurance in the classic sense**. It started functioning as a **payment plan for nearly all healthcare** – effectively, a costly way to finance medical care with little direct consumer control or awareness. The result? **Americans now often pay more, not less, for their healthcare, just through a different route (premiums and hidden wage deductions)**.

The Distortion of Employer-Sponsored Insurance (ESI)

How We Got Here – A Historical Quirk: You might wonder, if this setup is so inefficient, why did we ever do it? The answer lies in a bit of history and well-intentioned policy that had unintended consequences. **During World War II, the U.S. government-imposed wage freezes** – companies couldn't lure scarce workers with higher pay. In response, employers started offering health "benefits" to compete for talent, since benefits weren't subject to the wage freeze. In 1943, the IRS affirmed that **employer-provided health insurance would not be counted as taxable income or wages**. This tax advantage made health benefits hugely attractive. After the war, this practice was cemented by legislation that codified tax-free status for employer health benefits. What began as an emergency wartime workaround turned into the foundation of American healthcare financing. **Several generations later, getting health insurance through your job became the norm** – expected by workers (often as the centerpiece of benefit packages) and encouraged by government policy.

Insurance Tied to Employment: This employer-sponsored insurance (ESI) system means most people don't buy health coverage on their own; they get a plan chosen by their employer. On the surface, it looks like a nice perk – a "benefit" of the job. But as we explored in the previous chapter, that benefit is not truly *free*. Workers **pay for it indirectly through lower wages or reduced other compensation**. Employers treat the insurance premium as part of labor costs. In fact, roughly 30% of employee compensation costs to employers now go to benefits, with health insurance being the largest component. That's money that ultimately comes out of workers' productivity, which could have been wages. **So, you're paying – just in a hidden way.** The myth that your company is giving you health insurance was exposed in Chapter 1; now we see

that not only are you paying, but **the money is buying something far different from true insurance**.

ESI's Distorted Design: Employer-based health plans became **unusually comprehensive**, covering a wide array of services with low point-of-service costs for the patient. Part of this was driven by competition for talent (rich benefits attract employees) and partly by the tax subsidy (better to give compensation as health coverage, which is tax-free, than as salary which would be taxed). Over decades, this led to health plans that cover everything from doctor visits and prescription drugs to preventive screenings and even gym discounts. While it's nice to have many services covered, it came at a price: **premiums rose relentlessly**, year after year, because more spending simply translated to higher costs passed along in premiums. **As a country, we fell into financing our routine healthcare through insurance premiums rather than direct payment**, largely via our jobs, without fully realizing the consequences.

Losing Sight of Insurance's Purpose: This ESI model has largely **forgotten the original purpose of insurance**. Instead of a safety net for rare calamities, health insurance became a mechanism to prepay virtually all care. It's as if we decided that because grocery bills are important, we should all have "food insurance" where your employer pays a grocery plan that covers your bread and milk – and you pay a high monthly premium for it, plus copays at the store. No one would design a system like that deliberately, because it's obviously inefficient and obscures the true cost of a loaf of bread. Yet that's essentially what happened with healthcare. We **ignorantly (or at least unintentionally) engineered a system where routine health expenses are laundered through insurance**. The typical American family's healthcare spending mostly flows through premiums and employer benefit departments, not out-of-pocket at point of care.

This has had sweeping effects: it shielded people from seeing prices, it fueled medical price inflation, it tied health insurance to employment (creating job lock – fear of losing coverage if you switch jobs or start a business), and it gave insurers and employers enormous influence over which treatments and providers are used. All the while, individuals felt insulated from costs on the front end, even as those costs showed up in stagnant wages and higher premiums year after year.

What Insurance *Should* Be (vs. What It Has Become)

To recap, **insurance should be** about **security and catastrophe protection**. The ideal insurance setup in healthcare would mean:

- **Coverage for the Big Stuff:** If you have a bad accident, a cancer diagnosis, a complex surgery – you're protected from ruinous bills. The insurance kicks in when bills soar into the tens or hundreds of thousands, the kind of charges no average family can comfortably absorb.
- **Personal Responsibility for Routine Care:** For small, routine, expected expenses, you would pay directly (or via a modest health savings fund or similar). This keeps you **price conscious**. Doctors and clinics, in turn, must keep prices competitive and transparent to attract cost-conscious patients. It's akin to paying for your own new tires or house

painting – you might shop around or consider necessity, because you feel the cost directly.

- **Affordable Premiums:** Because the insurance isn't paying for every little thing, the premium you or your employer pays could be much lower. It is only pricing in the risk of major events, which are rarer. Such a policy looks more like true catastrophic health insurance – high coverage caps for disasters, but maybe a high deductible or limited coverage of everyday items.
- **Aligned Incentives:** With a clear separation of roles, insurers would focus on managing and pricing risk for rare events (and competing to offer the best protection at the lowest price), while providers focus on value for routine services. Individuals would have the incentive to stay healthy and avoid minor claims (since those come out of their pocket up to a point), and insurers would have the incentive to prevent major claims (through, say, wellness programs or good care management), because prevented hospitalization is a saved large payout.

Unfortunately, today's typical health plan – especially those provided through employers – **fails on many of these fronts**. It often has *first-dollar* coverage for routine care (at least after a small copay), **blurring the line between an insurance function and a payment plan**. It comes with high premiums that strain both employers and employees. It can still leave individuals with high out-of-pocket costs (through rising deductibles) *and* high premiums – the worst of both worlds, that I would like to point out: when premiums and deductibles are outrageously high, "there's no real risk transfer left" for many middle-class families. People end up paying a lot, often for limited value.

The Cost of Misusing "Insurance"

When insurance becomes a bill-payer, costs explode: The American healthcare financing approach has led to astonishing costs. We spend far more per person on healthcare than any other country, yet many Americans don't feel financially secure if they get sick. By using insurance for everything, we built in layers of cost. Every doctor's visit might involve your employer's HR department, an insurance company's bureaucracy, and a tangle of negotiated rates – all just to pay for a service that, had it been transacted directly, might have been simpler and cheaper. It's as if every time you buy a medication, three other entities take a cut or add a procedure on top. No wonder a pill that costs a few cents to make might bill at several dollars, or an MRI can be thousands of dollars in the U.S. but a fraction overseas.

Who pays in the end? We all do. We pay through *premiums deducted from our paychecks*, through *lower wages because our employer's money went to insurance*, through *taxes that subsidize employer plans (since they are untaxed benefits)*, and through *out-of-pocket costs when we use care*. The financing method is convoluted, but the working family ultimately bears the burden. The tragedy is that for all this spending, the system still leaves many feeling insecure – worried that if they need care, they'll face barriers, narrow networks, or surprise bills. In essence, **we pay Cadillac prices and often getting jalopy performance** in terms of financial security and satisfaction.

Restoring the True Meaning of Insurance

So, what should insurance be? **Insurance should be our financial safety net, not a routine payment plan.** It should resemble the straightforward deal we have with our auto or home insurers: *we handle the ordinary, they handle the extraordinary.* If we could realign health insurance to that principle, we'd likely see lower costs and saner incentives. In fact, some emerging models (like high-deductible health plans paired with Health Savings Accounts, or the Direct Primary Care movement mentioned in our analogy) attempt to move in that direction – **carving out routine care from insurance and reserving insurance for big-ticket items**.

The Road Ahead – Confronting the Status Quo: However, moving back toward "real insurance" in healthcare means confronting the entrenched system of ESI and insurer incentives that thrive on the status quo. As we transition to the next chapter, keep in mind the ideal we've outlined here. **Insurance done right pools our risks to protect us; it doesn't profit by keeping us in the dark or encouraging waste.** Unfortunately, the current employer-based insurance system has warped those incentives. In the next chapter, we will explore a stark reality: **the very "benefit" that is supposed to protect you financially has been engineered in a way that can keep you broke – because insurers and other players often profit more when you and your employer spend more on healthcare.** In a perverse twist, many insurance companies today actually **benefit from higher healthcare utilization and costs** rather than lower ones, due to how they structure premiums and revenue. Understanding this incentive problem is key to grasping why costs keep rising and why simply having insurance doesn't guarantee affordability or peace of mind.

In conclusion, true insurance is a shield against misfortune – a communal protection against the worst-case scenario. It's time to measure our current system against that standard. By recognizing how far we've strayed from what insurance should be, we can better understand the urgent need for reform and innovation. After all, if your "insurance" isn't protecting you from catastrophe – or worse, if it's contributing to your financial distress – then it's not really serving its fundamental purpose. The next chapter will dive into how employer-sponsored health insurance became "the benefit that broke us" by flipping the script of insurance and how we might reclaim the original promise of insurance as genuine protection.

Key Takeaway

As long as insurers earn more when costs go up, they will never be true partners in reducing healthcare spending. The system is structurally designed to encourage more claims, more utilization, and more inflation—because that's how the revenue grows.

Chapter 3: The Incentive for Excessive Utilization in Health Insurance

Insurers Profit from More Claims (Excessive Utilization Incentives)

Health insurance is often touted as a key workplace benefit – a safety net to protect you from catastrophic medical costs. But as we've seen in earlier chapters, this "benefit" has become staggeringly expensive and is straining workers and families. In this chapter, we examine why the system itself keeps driving costs higher, lining insurers' pockets while squeezing everyone else. We'll explore how insurance companies profit when more health care is used, why the **80/20 medical loss ratio rule** ends up rewarding higher spending, how administrative fees and other charges rise with volume, and how insurers even earn investment income from holding your premium dollars. We'll also connect the dots to what this means for you: higher premiums, lower wages, and a financial burden on working families. By understanding these dynamics, you'll see that the very structure of our health insurance system is *designed* to keep you paying more – essentially, a benefit that broke you and is poised to keep breaking you.

When More Health Care = More Profit

Intuitively, one might think insurance companies lose money if health care usage (and claims) goes up. After all, they must pay those doctor and hospital bills, right? Surprisingly, under our current system, **insurers often profit from excessive utilization of health care services.** The reason lies in how premiums and insurer margins are structured. Insurers typically price premiums to cover expected medical claims *plus* a markup for administrative costs and profit. If total claims rise, insurers can charge higher premiums the next year to cover those costs – and since their allowed profit is often a percentage of the total, a bigger dollar amount flows to their bottom line.

A key piece of this puzzle is the **medical loss ratio (MLR)** requirement established by the Affordable Care Act. The law's **"80/20 rule"** says insurers in the individual and small-group markets must spend at least 80% of premium revenue on medical claims (and 85% in large-group employer markets), leaving the remaining 20% (or 15% for large groups) for administration, marketing, and profit. On the surface, this was meant to protect consumers by capping how much insurers keep. In practice, however, it created a *perverse incentive*: since an insurer's profit margin is essentially locked at, say, 15% of premiums, the only way to earn more in absolute dollars is to **let those premiums (and claims) grow**. It's akin to a construction contractor paid on a cost-plus basis – if they get a fixed 15% of the project cost, a more expensive project means a bigger paycheck for them. Similarly, an insurer that must spend 80–85% on care might not aggressively fight to *lower* health costs, because doing so shrinks their slice of the pie (even if the percentage stays constant). How I best explain it, the ACA "introduced a cap on insurance profit margins but not profit levels" – insurers are *"supposed to spend 80% of every dollar on care and only 20% on administrative costs. However, instead of*

lowering premiums, [they] have been incentivized to increase costs so that they can make more money." In other words, **the more that health care costs rise, the more dollars insurers get to siphon off**.

This dynamic helps explain why medical loss ratios have settled in a high-but-steady range rather than pushing ever higher. In recent years, the average MLR has hovered around 82–88%, depending on the market. That means about 12–18 cents of every premium dollar are not used for medical care, but for overhead and profit. Insurers ensure they meet the minimum MLR requirements (to avoid rebates), but they have little incentive to go far beyond that. If an insurer somehow managed to spend, say, only 70% of premiums on care (thereby using just 30% for overhead/profit), they'd likely have to issue rebates under the law. Far easier is to *allow* costs – and premiums – to keep rising, comfortably meeting the minimum spending threshold while pocketing their fixed percentage on a larger sum. This is why industry margins remain **consistent in percentage terms** but **growing in dollar terms**. It's not an accidental outcome; it's by design. The 80/20 rule, meant as consumer protection, has ironically turned into a steady profit guarantee for insurers. They operate a lot like a utility with a guaranteed return on costs – except here, higher costs can boost their earnings.

To put concrete numbers on it: in the fully insured employer market, insurers' MLRs are roughly 85–86%. So, on an average family premium now exceeding **$25,000** a year, about **$3,750 or more** is available for the insurer's administrative expenses, marketing, and profit. If that family's health costs double and the premium jumps to $50,000 (spread between employer and worker contributions), the insurer still spends ~85% on care – but now has **$7,500** for overhead/profit instead of $3,750. Thus, higher utilization or prices directly translate into more revenue that isn't going to care. No wonder one health economist quipped that under the 80/20 rule, **insurers are in the business of "paying for health care and making money *because* health care is expensive."** The incentives are backwards – and you pay the price.

Administrative Fees: More Volume, More Revenue

Beyond the regulated insurance markets, there's another huge segment of health coverage: **employer self-funded plans**, where the employer bears the claims risk and insurers act as administrators. More than 60% of U.S. workers with employer coverage are in self-funded plans. You might assume that if an employer is paying all the claims, the insurer (as a third-party administrator, or TPA) has every reason to help control costs. But here too, the reality is that **administrative fees are often linked to volume**, meaning the insurer still doesn't suffer when costs soar – in fact, they can benefit.

When a company self-funds its health plan, it typically hires an insurance carrier or dedicated TPA to handle the plan's operations: processing claims, managing provider networks, negotiating discounts, customer service, etc. The TPA charges an **administrative fee**, usually either a flat amount per employee or per member per month (PEPM/PMPM) or sometimes a percentage of claims. For large employers, these fees tend to be negotiated at a fixed rate per enrollee. Recent analyses show that the big three administrative service carriers – United (Optum), Cigna, and Aetna – have been charging on the order of **$225 per enrollee per year** on average for their admin services. That works out to roughly $18–$20 per member each month.

(Smaller employers often pay even more, since they lack negotiating leverage.) In 2023–2024, these fees have crept even higher, now averaging somewhere in the **$240–$280 per enrollee per year** range for many employer plans – a not insignificant cost passed on as part of premiums.

Importantly, these **direct admin fees** are just one piece of how insurers make money on employer plans. Many administrative agreements include additional charges that *scale with usage*. For example, insurers levy **"network access fees"** – essentially a cut for providing access to their contracted provider network – which can be a **percentage of every claim paid** or a PEPM fee that increases with high-cost claims. They also may charge for "medical management" programs, disease management, utilization review, and other add-ons on a per-member basis. And virtually all big insurers also own **pharmacy benefit managers (PBMs)** or other service vendors, allowing them to earn money on each prescription filled or each service processed. In practice, this means that as the **volume of claims and services increases, the total fees and revenue the insurer/TPA collects tend to increase as well**. For instance, an insurer's PBM arm might receive a larger rebate (which it often partially keeps as profit) if more expensive brand-name drugs are utilized. Or the insurer may own clinics, labs, or provider groups so that some of the "claims" actually get paid to its own affiliates – effectively turning claims expenses into another revenue stream. The result is a subtle but powerful incentive: even in self-funded arrangements, where the insurer isn't on the hook for medical bills, they can still **profit from a higher volume of services**. They are certainly not motivated to aggressively curb over-utilization – doing so would shrink those network fees, PBM earnings, and related revenues.

Another way to view it: Insurers acting as administrators have a **captive client in the employer** – one that will pay a set fee per member and absorb all the medical costs. The insurer's primary goal becomes keeping that client happy enough to stick around (which often just means reliably paying claims and avoiding major administrative snafus), rather than heroically cutting costs. If medical spending for the employer's plan balloons, it's unfortunate for the employer, but the insurer can still collect its fees. In fact, sometimes high spending prompts employers to seek even *more* services from the insurer, like care management programs or specialty networks – which come with extra fees. The fox not only is guarding the henhouse; it's charging by the hen, and if more hens wander in, the fox happily collects a larger check.

To be fair, not all TPAs charge purely on volume; many are flat PMPM fees, and insurers do implement cost-control programs. But the **structural incentives** are weak. There is no robust reward for truly cutting employer health costs (if anything, it might reduce an insurer's admin revenue next year when premiums are lower). This fee-for-service administrative model, much like fee-for-service medicine, generates revenue in proportion to activity – and thus tends to **perpetuate high activity (and high costs)**. One Health Affairs study noted bluntly that big insurers' ASO fees were significantly higher than those of independent TPA, suggesting that large carriers are extracting economic rents rather than passing on efficiencies to employers. In summary, whether an insurer is fully underwriting a policy or just administering a self-funded plan, **more expensive health care often leads to more money in their coffers**. It's a heads-I-win, tails-you-lose setup for the carrier.

Working the Float: Investing Your Premium Dollars

Insurance isn't only about premiums and claims; it's also about **cash flow**. When insurers receive premium dollars (or, in the case of Medicare Advantage, large monthly payments from the government), they don't turn around and pay it all out immediately. There's typically a lag – sometimes months – between collecting funds and paying providers or reimbursing claims. In the interim, those funds sit in accounts, and insurers invest them in short-term instruments like bonds and money markets. This generates **investment income** – essentially profit earned from holding *your* money before it's used for your care. This practice is known as **"working the float,"** and while it's common to all insurance lines, it has become especially lucrative lately due to rising interest rates and huge growth in programs like Medicare Advantage.

Back in 2007, the Medicare Inspector General noticed this phenomenon and estimated that Medicare Advantage (MA) insurers earned about **$376 million in a single year just from investing the Medicare funds they received in advance**. These were taxpayer dollars given to insurers to fund care, but by timing payments advantageously, the plans got to pocket investment returns. The OIG suggested that if the government simply paid the plans a bit later (closer to when costs are incurred), the Medicare trust funds could have retained about **$450 million in interest in 2007** that instead went to the insurers. The Centers for Medicare & Medicaid Services (CMS) ultimately did *not* act on that recommendation, and private plans have continued to enjoy interest income on Medicare's dime. As Dr. Don McCanne of Physicians for a National Health Program commented, insurers receiving **"hundreds of millions of dollars by investing advance payments"** is "not unusual since all insurers work the float… The longer they can hold on to premiums before they pay out benefits, the greater the returns from investing those funds." In short, it's a built-in perk of the business.

Fast-forward to today, and the scale has exploded. Medicare Advantage enrollment has surged – over **32 million people** are enrolled as of 2024, accounting for more than half of all Medicare beneficiaries. The government is projected to pay MA plans more than **$473 billion in 2023** for those enrollees. Meanwhile, interest rates have climbed to their highest levels in about 15 years. Put those together: insurers are holding *hundreds of billions* of dollars (often getting monthly capitation payments upfront), and even parking that money in safe short-term investments can yield 4–5% annual interest. **That translates to a few billion dollars per year in pure investment income industry-wide from Medicare Advantage "float" alone.** Indeed, analysts have observed that 2023 was a banner year for health insurers' investment gains – net investment income across U.S. health insurance companies jumped about **33% in 2023 to $10.7 billion**, a boost partly attributed to higher interest rates and the sheer growth of premiums flowing through their accounts.

It's worth noting that this investment income isn't subject to the MLR calculations in the way premiums are. The 80/20 rule looks at how premium dollars are spent on medical claims; it doesn't say anything about money made *on the side* through interest. In other words, if an insurer receives $1,000 in premium and by the time it pays claims that $1,000 has generated $50 in interest, the $50 is basically free and clear – the insurer can count $800 of the $1,000 toward medical expenses (80% MLR) and still keep the $50 interest as extra profit without affecting the ratio. This creates a subtle incentive to maximize the float: ensure premiums (or government

payments) come in as early as possible, and pay out as late as is reasonably allowed. Some insurers have been known to be slow payers or to implement bureaucratic hurdles (like certain prior authorization delays) that, intentionally or not, can prolong how long they hold on to funds. Even a few weeks of delay, multiplied over billions of dollars in claims, can yield significant interest.

The **Medicare Advantage program** highlights the policy implications of the float. Because the government advanced funds to private plans without accounting for the interest those plans would earn, **taxpayers effectively subsidize insurer profits through interest**. As noted, regulators considered recouping this by adjusting payment timing or bids, but lobbying and complexity stymied changes. Thus, in our current system, insurers get yet another revenue stream that adds *no health value* – it's purely a financial maneuver made possible by the structure of payments. In a very real sense, a portion of your premium (or your tax dollars for Medicare) is working harder for the insurer's investment portfolio than for your health care.

The Soaring Price of Your "Benefit"

All these mechanisms – percentage-based profit margins, volume-linked fees, investment of float – might seem abstract, until you see the end result on your insurance bill. The average cost of employer-sponsored health insurance has been climbing relentlessly, and each year the **dollar amounts involved reach new records.** In 2023, the average annual premium for a family plan through an employer in Nebraska reached **$33,968**. By 2024, it jumped another 7%, crossing **$38,500** (almost **$40,000** per family per year). To put that in perspective, that's like **buying a new economy car every year** just to secure health coverage for a family. Employers bear a lot of that cost (typically about 72–75% of the premium), but workers still paid roughly $6,300 of it directly in 2024 – and even the employer's share ultimately comes out of workers' total compensation, as we'll discuss shortly.

Crucially, **a significant chunk of these premium dollars never goes to any doctor, hospital, medication, or therapy.** Thanks to the structural factors we've discussed, roughly **15–20% of your premium is consumed by administrative overhead, marketing, and insurer profit**. In dollar terms, for a family paying $40,000 a year in premiums, about **$5,900–$9,200 per year** is not actually providing health care – it's fueling the insurance apparatus itself. That is the cost of doing business with private insurers under the current model. Another way to think of it: every single month, a family is spending around $525–$835 on things like insurance company executive salaries, claims processing bureaucracies, sales commissions, advertising, and corporate profit, rather than on medical services for their family. Over the course of a decade, that could easily amount to $10,000 or more **per family** diverted to non-care expenses.

Where does that money ultimately go? A look at insurer financial reports gives a clue: it goes to **record profits and corporate growth.** The nation's largest insurance companies are enjoying unprecedented earnings. In 2022, the four biggest players (UnitedHealth Group, Cigna, Elevance/Anthem, and CVS/Aetna) together pulled in over **$41 billion** in net profit. In 2023, despite higher utilization post-pandemic, the top six insurers (adding Humana and Centene to the above list) still raked in roughly **$47 billion** in combined profits. To put it plainly, tens of billions of dollars each year are being extracted from the premiums we all pay, and are showing

up as profits on the ledgers of a handful of companies. Major insurers' CEOs and shareholders are, of course, pleased with this trajectory. For example, UnitedHealth Group alone posted $22.4 billion in profit in 2023 – an all-time high that outstrips the entire annual GDP of some small countries. These numbers are not coincidences or simply the result of excellent management – they are *built on the structural design* we've examined: a system that rewards expansion of the premium dollar.

It's also telling how stable insurer margins (as a percent) have been even as profits balloon. It indicates that **those margins were not squeezed by market forces or competition** – rather, insurers have found ways to keep that 12–18% overhead slice intact or even fattened. While hospitals, doctors, and drug companies often get (deserved) scrutiny for driving up health costs, the insurance layer quietly takes its cut of every dollar increase. When hospital prices rise or a new expensive drug hits the market, insurers pass along the cost in premiums – and then *add their markup on top*. It's a bit like a payment processor that charges a percentage fee: the bigger the transaction, the more they make, even though their service provided is the same. No wonder then that insurance executives are not sounding the alarm on high health care prices – **those high prices are, ironically, helping fuel insurance industry revenue**. This is the broken benefit at work: by design, your insurance coverage becomes more profitable to the company as it becomes more costly to you and your employer.

How You Pay: Stagnant Wages and Rising Burdens

We've talked about premiums and profits, but let's bring this back to **you, the employee or consumer**. Ultimately, the ever-increasing cost of health insurance doesn't come out of thin air – it comes out of workers' pockets, one way or another. Employers typically budget for total compensation (wages + benefits). When health insurance premiums gobble up a larger share of that pie, there's less left for wage increases. Economists widely agree that **rising health insurance costs lead to suppressed wage growth over time**. In other words, money that could have given you a raise has instead been funneled into the health care system via insurance premiums.

How big is this effect? Consider this stunning finding: **over the past three decades, the average family with employer-sponsored insurance effectively lost out on an estimated $125,000 in potential earnings** because compensation growth was diverted to health premiums instead of wages. In 1988, health insurance premiums were about 8% of an average worker's total compensation. By 2019, that share had ballooned to nearly 18%. That means nearly one-fifth of what employers spend on the average worker now goes to health insurance. This illustrates how this burden has grown disproportionately for low- and moderate-income workers over time, since premiums are largely flat amounts and thus eat up a larger fraction of a smaller paycheck:

Share of worker compensation going to health insurance premiums by income level (1988 vs 2019). Lower-wage workers spend a far higher portion of their total pay on premiums, a disparity that has worsened over time.

As shown above, by 2019 lower-income workers in the 20th percentile saw about **29% of their total compensation** absorbed by health insurance premiums, compared to just **4%** for workers

in the top 5%. This highlights an ugly truth: the skyrocketing cost of the health benefit hits hardest on those who can least afford it. Employers often pay a fixed percentage of the premium, so a high premium represents a bigger sacrifice of potential wages for a low-wage worker than for a high-wage one. The researchers of that study concluded, *"Our results depict the hidden costs of increasing health insurance premiums for the U.S. worker: less opportunity for wage growth and a heavier burden of health insurance premiums on lower-paid workers."* In effect, **the health insurance system is redistributing income away from workers (especially low-income and minority workers) to sustain ever-higher health care spending and insurer revenues**.

Beyond wage stagnation, employees are also paying more *directly*. Worker contributions to premiums have risen (even if employers cover most of the increase), and out-of-pocket costs like deductibles have climbed as well. It's not uncommon now for a worker to have, say, a $1,500 deductible and 20% coinsurance *in addition* to, perhaps, a $500 monthly paycheck deduction for the premium. Families thus feel the squeeze in multiple channels: paycheck deductions, out-of-pocket medical bills, and the absence of pay raises that were absorbed by insurance costs. It all adds up to what many call the **hidden wage cut** – your total compensation might be increasing on paper, but you don't feel it, because that increase is consumed by the health benefit that is supposed to help you.

In real terms, this means working families have less disposable income, may struggle to save, and often live one medical bill away from financial distress despite "having insurance." It's a painful irony: the very benefit meant to protect your health and financial security has become *so expensive* that it undermines your financial well-being. In economic terms, workers are paying a health-care tax, albeit one that goes to private insurers and health care providers instead of the government. And unlike a public tax, this one has been growing without much oversight of where the money goes.

Conclusion: Trapped in a Vicious Cycle

The evidence is clear: our employer-based insurance system and its private insurers have engineered a loop that keeps costs high and growing. Insurers profit from higher utilization and prices, thanks to the percentage-of-premium structure enshrined by the MLR rules. They earn steady fees (and often more) as claims volumes rise in self-funded plans. They even earn investment income by holding onto the dollars meant for your care. All these funds ultimately come from the same place – our collective paychecks and premiums – and increasingly, those funds are *not* buying more health or better care, but are feeding the machinery of the insurance industry itself. The "benefit" has, in many ways, **broken the bank for American workers**, yet the system is set up so that it keeps itself going in that state, year after year.

Insurers, of course, argue that they provide valuable services – negotiating discounts, managing risk, coordinating care – and that their slice of the dollar is the cost of doing that business. But as we've seen, that slice (12–18% of a massive and growing pie) is far from trivial, and the incentives in place encourage the pie to keep getting bigger. Meanwhile, it's the rest of us who feel the impact: wages that don't rise with productivity, premiums that take a bigger bite out of household budgets, and billions of dollars of our money diverted to activities only tangentially

related to health care delivery. We're essentially stuck paying a **perpetual tax to the insurance industry**, one that increases as health care costs increase.

Is this by intentional devious design or an unintended consequence of trying to regulate insurers? Arguably a bit of both – the ACA's MLR rule didn't *intend* to create a perverse incentive, but any industry will respond to financial incentives, and insurers have certainly responded to this one. The design of employer-based benefits didn't *intend* to suppress wages, but it absolutely has, and companies have long understood they trade off benefits costs against pay. What's clear is that **without changes, the system will continue on this trajectory**, because each player is simply following the built-in rules: insurers raise premiums to cover costs (and get their cut), employers pay more instead of giving raises, and workers carry the burden. Breaking this cycle would require fundamental shifts – in how we regulate insurers' profits, in how we pay for care, or perhaps in moving away from this fragmented private insurance model altogether.

As we close this chapter, consider that **the status quo is not just a series of unfortunate events – it is a predictable outcome of the incentives and structures in place.** The health insurance benefit that was meant to shield you is, paradoxically, draining your resources. In the next chapter, we'll move from these systemic issues to the **human impact**: we'll see how families are coping (or not) with medical bills, why people are skipping needed care despite having coverage, and the mounting medical debt and stress on working Americans. The dollars and cents we discussed here translate into very real pain and tough choices for millions of people. *How* this broken benefit affects lives – and what can be done about it – will be our focus in Chapter 4, as we explore the growing burden on working families and patients caught in the crossfire of this unsustainable system.

Key Takeaway

As long as health insurance revenue is tied to the total cost of care, insurers will never be motivated to lower costs. The system is structurally designed to encourage more claims, more utilization, and more inflation—because that's how everyone in the chain gets paid.

Chapter 4: The Financial and Emotional Cost of Lost Health Coverage

When serious illness strikes, it unleashes not only a medical crisis but often a **financial and emotional storm**. In this chapter, we explore how the structure of employer-based insurance – governed by ERISA – can compound a family's hardship. We will look at the **financial incentives** that drive insurers' behavior and the **emotional toll** on individuals caught in the system. Through a hypothetical example, we'll see how a dedicated worker can suddenly lose coverage at the worst possible time, and we'll examine how insurers profit by holding down claims. Finally, we consider the **broader economic impact** – how decades of rising insurance costs have quietly taken thousands of dollars out of employees' pockets, hurting families and the economy.

Losing Coverage in a Health Crisis: A Hypothetical Example

Imagine a scenario: **John**, a 50-year-old assembly line worker, has labored faithfully for years, contributing to his employer's health plan. One day, he is diagnosed with an aggressive cancer. As John undergoes chemotherapy, the side effects and fatigue make it impossible for him to continue working full-time. After using up his medical leave, he faces an agonizing reality: he can no longer meet the "active employee" requirement for his job-based health insurance. Under the rules of his employer's ERISA-governed health plan, coverage is tied to employment status – if you're not working, you're no longer a participant in the plan. Tragically, John's failing health costs him not just his paycheck but also his health insurance when he needs it most. In fact, the U.S. Department of Labor notes that when workers lose their jobs or even have hours reduced, they **"often [lose] the health and retirement benefits that go along with working full-time"**.

Now John faces a **nightmare double jeopardy**: he is battling cancer *and* he's lost the insurance to pay for his treatment. Emotionally, this is devastating – on top of the fear and uncertainty of a life-threatening illness, he feels the rug has been pulled out from under him. Financially, the situation is dire. He could elect COBRA continuation coverage, but that would require paying the full premium (previously shared with his employer) just when his income has vanished. With family coverage in Nebraska averaging over **$40,000** per year in premiums, COBRA can be prohibitively expensive. John quickly realizes he cannot afford it for long. His options narrow to seeking coverage through an Affordable Care Act (ACA) marketplace plan or attempting to qualify for Medicaid. Either way, **the cost of John's care is shifted onto taxpayer-supported programs**, since ACA plans are subsidized and Medicaid is publicly funded. This cruel outcome is perfectly legal – **by losing his job, John effectively "falls off" the employer plan, allowing the insurer (and employer) to stop paying for his expensive care, which instead becomes **a burden on public insurance**.

This hypothetical story is, sadly, far from rare. Many Americans in mid-career face similar predicaments. Some cancer patients have reported losing their jobs (and insurance) during treatment and having to turn to Medicaid or ACA plans for coverage. Others feel "job locked," *forced to stay* in a job they might otherwise leave, simply to keep their health insurance. The

emotional toll of this situation cannot be overstated. Patients like John experience **intense stress and anxiety**: instead of focusing solely on recovery, they must worry about how to pay for scans, surgeries, or medications with no insurance safety net. Families may watch in despair as years of diligently paying premiums and "doing everything right" seem to mean nothing when illness renders a breadwinner unable to work. **Financial toxicity** – the stress of medical bills and potential bankruptcy – becomes yet another side effect of a serious illness.

How Insurers Benefit: "Dumping" Sick Individuals and Delaying Claims

From the insurer's perspective, John's departure from the health plan is financially advantageous. Insurers (and self-insured employer plans) are acutely aware that a small fraction of very sick individuals accounts for the majority of health costs. In fact, roughly **20% of patients drive about 80% of healthcare costs**. It is in the insurer's financial interest to minimize their exposure to these high-cost cases. **ERISA**, the federal law governing employer health plans, unfortunately creates conditions that *enable insurers to save money at the expense of sick patients*. Here are some ways insurers and employer plans **hold down claims and avoid paying for the sickest individuals**:

- **Dropping Coverage via Employment Status:** Insurers cannot openly cancel an employee's coverage just for getting sick – discrimination on the basis of health status is illegal. However, they **don't have to continue coverage if the person is no longer employed**. As we saw with John, once a serious illness forces someone out of work, their group health plan coverage ends. This effectively **"gets rid of" one of the sickest (and costliest) individuals** from the plan's risk pool, offloading that cost onto public programs. It's been observed that some employers might even design their health plans to *encourage* high-risk employees to opt out. Legal scholars warn that **self-insured employers have "tremendous freedom" under ERISA to design plans that appeal to healthy workers but are unattractive to those with serious health conditions**. For example, a plan might offer free gym memberships and routine care (great for healthy people) but impose **huge deductibles or exclude certain expensive treatments** for conditions like cancer. A high-risk employee faced with such poor coverage for their illness has little choice but to seek better insurance elsewhere – usually on the ACA marketplace – effectively **"dumping" the sick employee onto a taxpayer-subsidized plan**.
- **Delay and Deny Expensive Claims:** Even while sick individuals are still covered, insurance companies have developed tactics to delay or avoid paying large claims. This is sometimes cynically summarized as **"delay, deny, and hope the patient dies."** Insurers use bureaucratic barriers like lengthy pre-authorization processes, repeated requests for documentation, and multi-level appeals to postpone expensive treatments. Under ERISA, if an insurer wrongfully denies a claim, the **worst consequence** they face is being forced to **cover the cost of the treatment later – no punitive damages, no pain-and-suffering compensation**. In other words, **even if an insurer's refusal to approve a procedure leads to a patient's death, the plan's only liability is to provide the benefit it should have originally provided**. This lack of serious penalty **"protects insurers**

substantially" and means dragging their feet on a costly claim is largely a *low-risk strategy*. For the patient, of course, these delays can be catastrophic. Some patients cannot survive long waiting for an experimental therapy or a transplant approval; others may be forced to give up or settle for less effective treatment. As investigative reporting has found, **millions of Americans each year are denied payment for treatments by their insurers, often leading them to forgo care or resort to inferior options**. This practice boosts insurers' bottom lines – every month of delay is a month without paying out – but at an **unthinkable human cost**.

- **Rescissions and Fine-Print Loopholes:** *(Note: Thanks to the ACA, some of the worst abuses have been curbed.)* Before 2010, insurers in the individual market commonly engaged in **"rescission"** – canceling a policy after a person got sick, citing minor application errors. The ACA outlawed most rescissions for health reasons. However, employer plans can still cancel coverage for seemingly neutral reasons like administrative error or if a premium share isn't paid on time. Additionally, **plans exploit fine-print exclusions** whenever possible. For example, if a treatment can be deemed "experimental" or "not medically necessary" under the plan's definition, it gives grounds to deny coverage. Insurers write their policies to **limit the definition of necessary care**, which can cap what they have to pay. All these maneuvers serve a common goal: **limit the insurer's liability for big claims**.

The net result of these strategies is a system that **privatizes profits and socializes losses**. In good health, employees and their employers dutifully pay premiums (essentially *renting insurance* from the company). But when a severe illness hits, the **insurance may prove illusory** for the person who needs it most. Either the claim is **denied or delayed** until the patient can no longer fight it, or the person loses access to the plan entirely once they can't work. In both cases, the insurer significantly **reduces its payout**. The **financial burden doesn't disappear** – it's just shifted elsewhere: *to the patient's family, to crowdfunding campaigns, or to taxpayer-funded programs like Medicaid*. As one commentator put it, **"delay and deny" tactics mean the insurer only pays if absolutely forced, sometimes when it's already too late for the patient**.

The Human Toll: Fear, Stress, and Injustice

It's important to pause and recognize the **human impact** behind these dry financial calculations. For someone like John, the experience is **traumatic**. The emotional toll includes:

- **Fear of Untreated Illness:** Losing insurance in the middle of a health crisis triggers immediate fear: *How will I continue treatment?* Patients may skip doses of medication or delay procedures because they aren't sure what will be covered. This can directly harm their chances of recovery, creating a terrifying sense that their life is slipping through their fingers for financial reasons.
- **Overwhelming Stress:** Medical issues are stressful enough on their own; add the sudden loss of coverage and possible loss of income, and stress levels skyrocket. Patients and families find themselves **fighting on two fronts** – against the disease and against potential financial ruin. Stress can come from haggling with insurance representatives, filling out complex forms for new coverage, or mounting medical bills. Chronic stress not

only diminishes quality of life but can even **worsen health outcomes**, an especially cruel irony in this situation.

- **Sense of Betrayal and Injustice:** Many insured workers feel a profound sense of betrayal when the safety net they relied upon vanishes. They contributed to their health plan for years, believing it would be there in time of need. To be abandoned by that plan – whether through a claim denial or loss of eligibility – can instill anger, bitterness, and a feeling that the system is fundamentally unjust. This emotional response is not just anecdotal; it reflects a broader public frustration. **Insurance is supposed to provide peace of mind**, yet stories abound of people with insurance coverage facing bankrupting bills or being denied life-saving treatments. The result is a growing cynicism and despair about the healthcare system as a whole.
- **Family and Financial Anxiety:** When insurance drops a sick individual, families often scramble to pick up the pieces. Spouses and children worry not only about their loved one's health, but also about how to pay the mortgage or rent while medical costs pile up. In some cases, families resort to extreme measures – selling assets, emptying retirement savings, or pleading for help on GoFundMe. The **financial toxicity** of cancer and other serious illnesses can strain relationships and force painful trade-offs (e.g., do we pay for medication or the utility bill this month?). Even after the patient recovers or stabilizes, the **debt can linger for years**, a constant reminder of the ordeal.

In short, the **emotional fallout** of losing insurance in a health crisis compounds the suffering of illness. It transforms what should be a period of care and convalescence into one of **chaos and anxiety**. No financial metric can truly capture the sleepless nights, the panic attacks, or the heartbreak of having to choose between one's health and one's financial stability. But as we'll see next, there *are* ways to measure how this broken system affects workers' finances on a larger scale – and the numbers are staggering.

The Broader Economic Impact: Wages Lost to "Renting" Insurance

The problems discussed here don't just hurt individual families – they ripple out to affect the entire economy. Over the past few decades, **employer-sponsored insurance costs have ballooned**, consuming a growing share of what would otherwise be workers' wages. In effect, employees have been **"paying more and more for less and less security."** This hidden siphoning of compensation to cover insurance premiums has deprived workers of money that could have gone to other needs (housing, education, savings) and acted as a drag on economic growth.

Consider these findings from a recent analysis of health insurance and wages:

- **Premiums Crowd Out Wages:** In 1988, health insurance premiums accounted for about *7.9%* of an average worker's total compensation. By 2019, that figure had jumped to *17.7%*. In other words, nearly one dollar in every five of employee compensation is now eaten up by health insurance costs – money that **is not showing up in paychecks**. Researchers estimate that if health premiums had remained at the more modest share of

the late 1980s, the **average family would have earned about $8,700 more in wages per year by 2019**. That's essentially a lost annual income due to the **"rent" we pay to keep insurance coverage**.

- **Tens of Thousands in Lost Income:** Over the last 30 years, these premium-driven wage losses have accumulated massively. The average family with employer coverage effectively **lost about $125,000 in potential wages from 1988 to 2019** because of rising insurance costs. *One hundred twenty-five thousand dollars!* That is money that could have boosted consumer spending, gone into buying homes, or been saved for retirement. Instead, it was absorbed by the healthcare system's cost inflation. As one study author noted, **decades of rising health costs have "robbed Americans of substantial income"** and contributed to widening income inequality.
- **Worse for Low-Income Workers:** The burden of sky-high insurance costs doesn't fall equally on everyone. Lower-wage workers and workers of color spend a larger percentage of their income on premiums than higher earners. For instance, by 2019, health premiums represented **28.5% of total compensation for families in the bottom 20% of earnings**, compared to just 3.9% for families in the top 5%. That means those who can least afford it are giving up the biggest share of their pay for health insurance – often for plans with high deductibles and out-of-pocket costs that they then struggle to use. This dynamic **exacerbates economic inequality**, effectively taxing the poor and middle class more heavily in terms of foregone wages.

The economic consequences of our employer-based insurance system can be seen in **stagnant wage growth**. While workers became dramatically more productive over recent decades, their wage gains lagged. A significant reason is that **a big chunk of compensation growth was diverted into health insurance premiums instead of paychecks**. Workers *feel* like they're running in place financially, and in part they are – their raises have quietly been going to the insurance company. This also impacts the economy at large: when households have $9,000 less per year to spend or save, that's money **not flowing into other sectors** like retail, housing, or education. Consumer spending drives much of the U.S. economy, so siphoning off wages into healthcare can act like a brake on growth.

Moreover, when sick workers like John lose their jobs and turn to Medicaid or ACA subsidies, **taxpayers pick up the tab**. There is a societal cost to allowing private insurers to jettison the most expensive patients. Medicaid spending rises, ACA marketplace premiums rise (since the risk pool there gets sicker), and often the government must step in with higher subsidies or funding. Essentially, **employers and insurers offload liabilities and the public pays** – either through higher taxes or higher premiums in the individual market. One could argue this is an inefficient, backdoor way of financing healthcare that lacks the fairness and transparency of simply funding a robust public insurance system. Instead of every employer bearing the cost of their sick employees, the burden is shifted to society at large.

In summary, the **enormous inflated costs** of health insurance have hurt the economy by **stripping workers of disposable income** and burdening public programs. Employees have been losing out on thousands of dollars in compensation – money that they effectively spend to "rent" insurance coverage from their employer, coverage that, as we've seen, might not even be there for them in a pinch. This is both an economic problem and a moral one: Is it right that someone

can work hard and pay into a health plan for years, only to be financially stranded when they fall ill? As the data shows, the status quo has *not* been benign for American families' finances.

Conclusion: A System in Need of Reform

Chapter 4 has laid bare a harsh reality: **the intersection of health and employment in America can be financially devastating and emotionally distressing**. We saw through John's story how a health crisis can cost someone their insurance when they need it most, illustrating the cruel catch-22 built into our ERISA-based employer insurance system. We examined how insurance companies and employer plans, driven by profit motives, leverage that system to shed high-cost patients and delay expensive claims – tactics that pad their bottom line but can literally cost lives. The **human toll** is profound, as families grapple with fear, stress, and a sense of betrayal during what should be a time of care and support. And beyond the personal tragedies, we uncovered a larger economic injustice: **for decades, rising insurance costs have quietly eaten away at Americans' wages**, draining households of income and holding back broader economic prosperity.

The picture may feel discouraging, but recognizing these problems is the first step toward change. If there is a silver lining, it's that these outcomes are not inevitable – they are the result of policy choices and corporate practices that *can* be reformed. As we move to the next chapters, we will explore potential solutions and reforms that could alleviate these issues, such as strengthening patient protections, reconsidering the link between employment and insurance, and ensuring that the wealth of our nation is no longer siphoned off unchecked into healthcare costs. The stakes are incredibly high: it's not just about dollars and cents, but about **life, dignity, and peace of mind** for millions of Americans. The urgency for reform has never been greater, as the financial and emotional wellbeing of working families hangs in the balance.

Key Takeaway

The ACA was not a structural reform of health insurance—it was a structural guarantee of its existing inefficiencies. By tying subsidies to premium growth, preserving the employer tax exclusion, and mandating broad coverage regardless of cost, it created a permanent inflation loop that benefits insurers, hospitals, and pharmaceutical companies—at the direct expense of taxpayers, employers, and middle-class families.

Chapter 5: How Did We Get Here? – A Brief History of Employer Health Insurance

Health insurance tied to your job is so familiar today that we rarely question it. But step back and it seems an odd arrangement: we don't get our car insurance or home loans through our employers, so why health coverage? The answer is a winding journey through history – a tale of wartime quirks, tax breaks, rising costs, and political choices. This "accidental" system of employer-sponsored insurance became the backbone of American healthcare by the late 20th century, and every attempt to fix it has only reinforced its dominance. In this chapter, we'll trace how we got here, from the early days of health insurance to the present, to understand why getting coverage through work became the American way – and how it left those outside the system with a raw deal.

Before Employer Plans: When Health Care Was Personal

In the early 1900s, there was no grand plan linking health care to employment. Medical costs were modest and often paid out-of-pocket or through small local initiatives. An **individual health insurance market once existed**, albeit in a primitive form. Fraternal organizations, unions, and even some employers offered rudimentary medical benefit funds or access to company doctors for injuries on the job. Hospitals began experimenting with pre-paid plans: a famous example in 1929 had a Dallas hospital offering local teachers 21 days of care for a small monthly fee. This idea spread during the Great Depression as hospitals and doctors realized people couldn't afford care; these prepaid hospital plans became the origin of Blue Cross. In parallel, private insurance companies tentatively offered "hospital indemnity" policies and later surgical expense coverage, often sold to individuals. By the late 1930s, a person could buy a basic health policy on their own, and a handful of Americans did. Still, on the eve of World War II, most Americans lacked any health insurance – you paid the doctor or hospital if and when you needed care, and hoped for the best. Health coverage was a personal responsibility or a community charity, not a standard job benefit.

World War II and the Accidental Birth of Employer Insurance

World War II upended this status quo in a completely unexpected way. In the midst of the war, the U.S. government was desperate to control inflation. Factories were booming and competing for scarce workers, which drove wages up. To prevent runaway inflation, in 1942 the government imposed strict wage freezes – employers could not raise pay to lure talent. However, there was a loophole: the authorities allowed "fringe benefits" (like pensions or insurance) to sidestep the wage controls since such perks were relatively uncommon at the time. In 1943, the War Labor Board explicitly ruled that employers could offer health insurance and other benefits without violating the wage freeze.

This was a game-changing decision. Companies suddenly had a powerful new way to compete for workers: if they couldn't outbid rivals with higher salaries, they would offer health insurance coverage instead. Like water finding a crack, the labor market flowed through this loophole. Employers big and small began adding health benefits to job offers. For workers, this was an attractive free extra in a time of war and scarcity. By the end of WWII, the number of Americans with health insurance had **tripled** in just a few years. What had been a rarity – job-based health coverage – was rapidly becoming a norm. An emergency wartime policy unintentionally planted the seeds of a nationwide employer-based health insurance system.

Tax Breaks Cement the System in the 1950s

If WWII gave employer health benefits an initial boost, the postwar period locked them in with financial cement: **favorable tax treatment**. After the war, employers and labor unions continued to expand health benefits. Unions often pushed for better health coverage in contract negotiations, seeing it as an important new component of worker compensation. Employers, for their part, noticed that providing insurance was a relatively cost-effective way to satisfy workers – especially if the government helped foot the bill through tax incentives.

A critical moment came in 1954, when Congress revised the Internal Revenue Code and codified a policy that had been informally in place: employer contributions to health insurance would **not count as taxable income for employees**. In plainer terms, if your company paid $1,000 for your health insurance premium, you did not pay a cent of tax on that $1,000 as you would if it were wages. Employers could also deduct the cost of health insurance as a business expense. This double tax benefit was huge. It meant both employers and employees saved money by funneling compensation into health plans instead of paychecks. A dollar of health insurance bought through your job went further than a dollar of salary in your bank account, because that salary would be taxed and whittled down.

This tax exemption might sound dry, but it supercharged the growth of employer-based insurance. It effectively made health coverage a **tax-free form of compensation**, something no cash wage could compete with. Companies eagerly expanded benefits, and workers came to expect them. Through the 1950s, millions more Americans enrolled in health plans sponsored by their jobs. By the end of that decade, roughly three-quarters of all people with private health insurance were getting it through an employer. What had started as a wartime workaround had, thanks to the tax code's encouragement, become the default. Employers were now firmly in the middle of American healthcare – whether they wanted to be or not – and the individual market for health insurance took a back seat. Buying your own policy seemed increasingly unnecessary (or unaffordable) if you could get coverage at work for a better price.

Dominance by the 1960s: An Accidental System Takes Over

By the 1960s, employer-sponsored insurance (often abbreviated ESI) was not just a perk for some workers – it was the main way the middle class obtained health coverage. The unintended system had matured: getting a good job often meant getting health benefits, and this was seen as a win-win. Employers used benefits to keep employees loyal, and employees relied on jobs for

security not just of income but of medical care. To put it in perspective, by the mid-1960s, a majority of Americans under 65 had health insurance through employment. It happened without a master plan, almost by historical accident and economic incentive, but it felt natural by then.

However, this job-based system had blind spots. Not everyone was in the workforce or had a benefit-offering job – particularly the elderly and the very poor. When these groups fell ill, they had little protection. The dominance of employer insurance thus set the stage for major gaps that the government moved to fill in 1965 with **Medicare and Medicaid**. Medicare provided health coverage to Americans over 65 (who, once retired, lost any employer insurance they had), and Medicaid offered coverage to certain low-income individuals and families. These programs acknowledged that the employer-based model left significant groups uninsured. Rather than replace the employer system, the government chose to patch around it: ESI would cover working families, and public programs would cover the retired, disabled, and poor. By the late 1960s, the U.S. had stumbled into a hybrid approach – part private, job-tied insurance, part government safety net – instead of the universal public insurance many other countries adopted post-WWII.

Through the 1970s, employer insurance entrenched itself even further. Health benefits became a standard expectation for full-time jobs. The term "fringe benefit" entered the American lexicon, implying health insurance was a routine add-on to wages. The accidental system was now institutionalized. Yet, trouble loomed: medical costs were rising sharply. As new hospitals, drugs, and technologies proliferated, the price of health care in America was climbing every year, and employers (along with government, in Medicare/Medicaid) were footing the bills. By the end of the 1970s, it was clear that simply paying whatever doctors and hospitals charged was unsustainable. The next chapters of this story involve efforts to control costs – and how those efforts further shaped the employer-based system we know today.

The 1970s: Early Cracks and New Regulations

In the 1970s, inflation hit the healthcare sector hard. Employers saw their health plan costs skyrocketing in tandem with broader economic inflation. Policymakers grew concerned that healthcare spending was out of control. The decade brought the first attempts to **rein in costs and organize care** in the employer market. One strategy encouraged by the federal government was the Health Maintenance Organization model. The **HMO Act of 1973** provided funding and a push for employers to offer HMO plans – a new kind of insurance where a patient's choices of doctors and hospitals were restricted to a network, and care was managed to emphasize prevention and cost efficiency. The idea was to move away from open-ended fee-for-service medicine (where more services simply meant more charges) toward something more budgeted. Many companies began to offer HMO options alongside traditional insurance by the late '70s, laying groundwork for the managed care revolution to come.

Another pivotal development was the passage of **ERISA (Employee Retirement Income Security Act) in 1974**. ERISA was primarily a pension law, but it had immense impact on health benefits. This federal law set minimum standards for private employer benefit plans and, crucially, declared that such plans would be governed by federal rules, **preempting state insurance laws**. In practice, ERISA meant that large employers who self-funded their health plans (paying claims out of company funds rather than buying a state-regulated insurance policy)

could avoid the patchwork of state insurance mandates and rules. Companies operating in multiple states loved this uniformity – it made providing benefits simpler and often cheaper. But ERISA also had a side effect: it **froze the basic framework of employer health benefits at the federal level**, insulating it from bold experiments by any individual state. States could reform their insurance markets for individuals or small businesses to some extent, but they couldn't touch most big employer plans. In short, by the end of the 1970s, the employer-based system was not only dominant; it was fortified by law and policy, even as questions grew about how to tame its rising costs.

The 1980s: Costs Surge and Employers Take Control

Healthcare costs exploded in the 1980s. It was a decade of double-digit annual increases in premiums. New medical technologies, expensive specialist care, and a "buy now, pay later" approach to billing (especially in traditional insurance where neither patient nor provider had much incentive to economize) drove spending upward. Employers suddenly found health benefits turning into a huge line-item expense, eating into profits and workers' wage gains. One study from the late '80s showed premiums for employer-sponsored insurance climbing around 15–20% per year – far outpacing inflation. For the first time, business leaders began to talk about health costs as a threat to competitiveness, complaining that American products were more expensive because companies had to build insurance costs into prices (famously, automakers lamented that each car's price included a few hundred dollars to cover employee healthcare).

In response, **employer control grew.** This was the era when the concept of **"managed care"** truly took hold in the private sector. Employers and insurance companies, desperate to curb expenses, started managing how and where employees received care. If the 1960s had offered generous, hands-off benefits, the 1980s introduced a more hard-nosed approach. Traditional open-choice, low-deductible health plans began to fade. Taking their place were HMOs and their more flexible cousin, PPOs (Preferred Provider Organizations), which formed networks of doctors and hospitals that agreed to discount rates. The trade-off: employees had to use these networks or pay more out of pocket, and insurers would scrutinize which services were truly necessary. Utilization review became common – hospitals had to get prior approval for expensive tests or longer stays, for example. Employees felt the difference: you might now need a primary care "gatekeeper" to refer you to a specialist, or find that the family doctor you'd seen for years was "out of network" under the new plan.

Employers also **shifted more costs to workers** during this time. The era of the company covering the full premium faded; employees were asked to contribute a portion of their premium via payroll deductions. Co-pays for doctor visits or prescriptions popped up and rose. Annual deductibles (the amount you pay before insurance kicks in) became more common. These tactics were meant to make employees more cost-conscious "consumers" of health care, curbing the tendency to overuse services since now they had some skin in the game. In effect, to keep the employer-based system viable, companies had to dial back the open bar of health coverage and put limits and cost-sharing in place – much to employees' frustration.

Government policy also adapted: in 1985, Congress passed **COBRA**, a law that acknowledged the disruption caused by tying insurance to a job. COBRA allowed workers who left a job to

continue buying into their former employer's health plan for a limited time (typically 18 months) as long as they paid the full premium. This was a lifeline for those in between jobs or early retirees who would otherwise lose insurance immediately, but it was expensive since employers no longer chipped in. COBRA was another patch on the system: it didn't fix the root issue (losing coverage when losing a job), but it provided a temporary bridge to mitigate shocks.

By the end of the 1980s, the landscape of employer insurance had changed significantly from two decades earlier. Most working Americans still got coverage through work, but now that coverage came with more strings attached and a growing share of costs paid by the worker. The employer-based model had survived the cost crisis of the '80s by evolving – however, the evolution often meant a tighter leash on patients and more financial burden on families. These trends would continue into the 1990s, as both business and government grappled with the ever-rising healthcare bill.

The 1990s: Portability and Expansion – HIPAA, ERISA and More

The 1990s saw further refinement and reinforcement of the employer-centric system. Early in the decade, there was a dramatic attempt at comprehensive health reform – the Clinton administration's plan in 1993–94 aimed to achieve universal coverage, largely by building on employer insurance (through mandates on employers to provide coverage) combined with regional purchasing alliances. That effort failed politically, leaving the status quo intact but with a clear message: the public and interest groups were not ready to uproot employer-based insurance. Instead, Congress turned to more incremental fixes that **shored up the existing model**.

A key piece of legislation was the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**. While HIPAA is often remembered for its privacy rules, its immediate impact was on insurance portability and access. HIPAA made it easier for employees to change jobs without losing coverage or facing new waiting periods for pre-existing conditions. Under HIPAA, if you had continuous coverage in a group health plan, a new employer's plan could not impose a pre-existing condition exclusion longer than 12 months, and any prior coverage credit would reduce that waiting time. Insurers and employer plans were also prohibited from outright excluding or charging an individual employee more due to their health status. In short, HIPAA helped people stay in the **employer insurance loop** by smoothing transitions between jobs. Importantly, however, these protections largely applied to group insurance; the law did relatively little to make individual insurance accessible. (HIPAA did require insurers in every state to offer some form of coverage to certain people leaving group plans, but those options were often pricey high-risk pools or bare-bones policies.) The net effect: HIPAA reinforced that the pathway to reliable coverage was to get into another employer plan quickly. It treated employer insurance as the default and sought to make that system more navigable, rather than encouraging a shift to an individual-based system.

Meanwhile, interpretations of **ERISA** continued to loom large. Courts in the '90s struck down several state laws that attempted to regulate managed care or give patients new rights, on the

grounds that ERISA preempted those state efforts for employer-based plans. For example, states that wanted to allow patients to sue their HMO for denials of care ran into ERISA's wall, which generally limited legal remedies under employer plans. This further solidified the employer model under a uniform federal umbrella. No matter what state you worked in, your big-company health plan likely followed similar federal rules and was insulated from many consumer-protection laws states applied to other insurance. The employer system was not only dominant; it was protected and **homogenized by federal law**.

Another development in the late '90s was the rise of new tax-advantaged ways to pay for health expenses, pointing toward the future of consumer-driven healthcare. Medical Savings Accounts (MSAs) were introduced as a pilot program, allowing a limited number of self-employed and small business employees to save pre-tax money for medical bills if they had high-deductible insurance. The idea was to counter rising costs by giving individuals more direct financial responsibility and choice. MSAs were the forerunner of what would become Health Savings Accounts in the next decade. While initially a niche, this concept signaled a continued faith that employers (and individuals) could manage costs by tweaking the financial structure of benefits, rather than by any radical systemic change.

By the end of the 1990s, employer-sponsored insurance was still covering the majority of Americans under 65, and policy tweaks like HIPAA had made it somewhat more secure to stick with that system. Yet the cracks were showing: premiums began climbing again after a mid-90s lull, and both employers and workers were growing weary. Small businesses in particular struggled to afford coverage for their employees, and many cut benefits or dropped plans, contributing to a rising number of uninsured Americans as the decade ended. Still, the momentum for change resulted in adjustments that, intentionally or not, **doubled down on employer-based coverage as the pillar of U.S. health care**.

The 2000s: High-Deductible Plans and Health Savings Accounts

In the 2000s, the pattern of escalating costs and incremental policy responses continued. Early in the decade, employers faced annual premium increases frequently in the double digits. To illustrate: in 2002 a typical family health premium might have been around $8,000; by 2010 it had more than doubled, approaching $15,000. Employers responded with an even heavier shift towards employee cost-sharing. This period saw the emergence of the **high-deductible health plan** paired with a new tool, the **Health Savings Account (HSA)**.

Authorized by federal law in 2003, HSAs allowed individuals (and employers on their behalf) to set aside money tax-free to pay for medical expenses, but only if they enrolled in a qualifying high-deductible insurance plan. The logic was straightforward: if patients have to pay more out-of-pocket (by virtue of a high deductible) but can use pre-tax savings to do so, they will shop more carefully for care, avoiding unnecessary spending. For employers, high-deductible plans were generally cheaper, and contributing a few hundred dollars to an employee's HSA still cost less than the premium difference of a more generous plan. Throughout the 2000s, more companies started offering these **consumer-driven health plans** as options – or even as the only

option. The HSA law thus reinforced the employer model by giving companies another cost-control lever (and a new tax-free fringe benefit to offer), rather than encouraging any move away from job-based coverage.

Tax policy in general remained favorable to employer coverage. Proposals to limit the tax exclusion for health benefits – which economists often argued would help contain costs – went nowhere due to political fear of upsetting the employer-insurance apple cart. In fact, by the 2000s the tax exclusion for employer-provided health insurance was the largest single tax break in the federal budget, costing the government tens of billions in lost revenue every year. Yet neither party wanted to be seen as taxing people's health benefits, so the subsidy persisted untouched. The only notable change on the tax front was for the self-employed: by 2003, self-employed individuals were finally allowed to deduct 100% of their health insurance premiums for tax purposes, a slow correction to something that had long been an inequity. Still, people with traditional jobs effectively got a better deal (immediate untaxed benefits) compared to those buying insurance on their own (who, even if self-employed, had to pay upfront and deduct later, and those not self-employed got no break at all). The playing field remained heavily tilted toward the employer route.

By the late 2000s, the cracks in the healthcare system had widened into chasms. The number of Americans without health insurance soared to around 50 million (about 15–16% of the population). Many of these were working people whose employers did not offer coverage or who couldn't afford their share of the premiums. Small businesses were struggling to keep plans going. Big employers were groaning under costs but felt stuck as employees depended on their benefits. This all set the stage for the most significant health reform since Medicare: the Affordable Care Act. And once again, the question loomed – would this be the moment to break from the employer-based system, or would the new reforms continue to center it?

2010: The Affordable Care Act – A Turning Point That Entrenched the Status Quo

The passage of the **Affordable Care Act (ACA) in 2010** was a watershed in U.S. healthcare policy. This sweeping law aimed to cover tens of millions of uninsured people and to make insurance more accessible and comprehensive. Many observers wondered if the ACA would finally weaken the bond between employment and insurance – perhaps by making the individual insurance market a viable alternative for everyone, or by introducing public insurance options. In practice, the ACA ended up **solidifying employer-sponsored insurance as the core of the system**, even as it made significant changes around the edges.

From the outset, ACA's architects were careful not to threaten the coverage that the majority already had. "If you like your health plan, you can keep it," became a mantra – a political promise that essentially guaranteed that job-based plans would continue. Rather than move people out of employer plans, the ACA largely left those plans in place and focused on filling the gaps elsewhere. It created insurance **Marketplaces** (or Exchanges) where individuals without job coverage could buy health plans, with income-based subsidies to make them affordable. It also expanded Medicaid in many states to cover more low-income adults. These measures

drastically cut the uninsured rate. But the ACA also built in a sort of firewall: if you have an offer of employer coverage, you're generally **ineligible for subsidies** on the new individual marketplaces (unless your employer plan is extraordinarily expensive or skimpy). This provision effectively discouraged anyone from leaving a job plan for an individual plan. The message was clear – the new individual market was there as a safety net for those without offers of employer coverage, not a replacement for employer coverage.

Moreover, the ACA introduced an **employer mandate**: larger companies (50 or more full-time employees) would face penalties if they didn't offer health insurance to their full-time workers. This mandate was another signal that rather than dismantling the ESI system, the law would buttress it. Employers, especially large ones, overwhelmingly kept offering insurance to avoid penalties and because it remained an important recruitment tool. The feared scenario of companies dumping employees onto the new exchanges en masse largely didn't materialize. In fact, employer-sponsored coverage proved resilient post-ACA; the percentage of Americans with ESI held fairly steady, and as the economy recovered from the Great Recession, more people got jobs with benefits, actually modestly increasing ESI enrollment in the later 2010s.

The ACA did impose new rules on all health insurance, including employer plans. It set essential health benefits standards (mainly affecting small group plans), removed annual and lifetime coverage caps, and let young adults stay on their parents' employer policies until 26. It also planned to implement a tax on very high-cost employer plans (the so-called "Cadillac Tax") as a way to curb the most lavish, cost-driving benefits. However, that tax never took effect in the face of opposition; Congress repeatedly delayed it and eventually repealed it. The failure of the Cadillac Tax effort underscored how politically sacrosanct the tax-free status of employer health benefits remained.

In short, the ACA's legacy was somewhat paradoxical: it revolutionized parts of the insurance market (especially for individuals and small groups) and expanded public coverage, but it left the employer-based system largely in place – arguably even more firmly the center of American health financing. After 2010, if you had a good employer plan, you likely kept it and benefited from some added protections, but you probably didn't interact with the new exchanges or Medicaid expansion. If you lacked employer coverage, the ACA gave you options to gain insurance, yet those options were separate and distinct from the employer world. This leads us to the present fractured state of affairs.

A Fractured System: Two Worlds of Health Coverage

Seventy-odd years after World War II's end, Americans live in **two very different health insurance worlds** depending on whether they get coverage through an employer or not. This divide is a direct outcome of the history we've traced. On one side, there's the world of employer-sponsored insurance: group plans that follow one set of rules and enjoy sizable hidden subsidies. On the other side, there's the individual market (along with government programs) with a different set of rules and often greater challenges. The result is a system that can feel arbitrary and unfair.

If you're one of the roughly 160 million Americans with employer-based coverage, you typically benefit in several ways:

- **Economies of Scale and Group Rates:** Your employer pools you with many coworkers. Premiums are based on the health of the group, and large employers especially have bargaining power to negotiate better rates with insurers or healthcare providers. An individual buying alone doesn't have this leverage.
- **Employer Subsidy:** Most employers pay a significant portion of the premium – often 70-80% for the employee's own coverage, and perhaps a bit less for dependents. This means the cost deducted from your paycheck may be only a fraction of the plan's true cost.
- **Tax Advantage:** The portion of the premium you do pay is usually taken out of your paycheck pre-tax, and the portion your employer pays is entirely tax-free to you. Neither you nor your employer pays income or payroll taxes on those dollars. It's as if the government is quietly chipping in by forgoing tax revenue.
- **Generally Comprehensive Coverage:** Large employer plans tend to be fairly comprehensive (now mandated not to impose lifetime limits, etc.). Even before the ACA, such plans had to cover everyone regardless of medical conditions, and risk was spread across the workforce. After ACA, both group and individual plans must cover essential benefits and pre-existing conditions, but historically your job-based plan was far more likely to accept and adequately cover a person with health issues than the individual market was.
- **Stability (As Long As the Job Lasts):** Once you're enrolled, you typically remain insured year-round, renewing annually, and you don't have to shop around each year if you're happy. Your employer handles the heavy lifting of picking insurers or self-funding the plan. As long as you stay employed and the company offers benefits, your coverage continues, and you're somewhat insulated from premium hikes (you might see higher payroll deductions, but employers often buffer the increases).

Now consider those outside the employer system – for example, a **self-employed freelancer, a gig economy worker, an early retiree**, or anyone whose job doesn't provide insurance. Their experience is often quite different:

- **Higher Costs for Individuals:** Buying insurance on your own can be very expensive. Unless you qualify for income-based subsidies on the ACA Marketplace, you pay the whole premium, and there's no employer pitching in. A 60-year-old early retiree, for instance, might face premiums of many hundreds of dollars per month for a standard plan. Younger self-employed people might get somewhat lower rates, but still must pay it all themselves.
- **Tax Disadvantages:** If you're self-employed, you can deduct your health insurance premium on your tax return (a hard-won change by the 2000s), which helps somewhat. But if you're not self-employed (say you're working gigs or between jobs), there's usually no tax break; you're buying with post-tax dollars. There's no mechanism to exclude those premiums from taxable income the way employer benefits are excluded. Essentially, two people with the same income can spend $5,000 on health insurance, but the one who pays through an employer does it with pre-tax money and the one who buys individually pays with taxed money – a major difference.

- **Varied Quality and Access:** The individual insurance market today (post-ACA) is a double-edged sword. On one hand, you can get a decent comprehensive policy regardless of health status (insurers can't reject you or charge more for pre-existing conditions anymore). On the other hand, in many areas the choices of insurers might be limited, and plans often have **narrower provider networks** to keep costs down. That might mean fewer doctors and hospitals to choose from compared to a typical big employer PPO plan. Additionally, many individual plans are high-deductible, requiring patients to pay thousands out-of-pocket before insurance truly kicks in, partly because individuals often opt for lower-premium plans which come with higher cost-sharing.
- **Greater Instability:** Outside the employer realm, coverage can feel less stable. Individuals have to remember to renew their plan or shop for a new one every year during open enrollment, potentially juggling changing premiums and plan networks annually. If your income fluctuates (common for self-employed or gig workers), you might gain or lose eligibility for subsidies or certain programs, leading to changes in coverage. Losing a job triggers a special enrollment opportunity, but it's on the individual to navigate that. By contrast, those with employer insurance just go with whatever their employer negotiates each year, with far less hassle on the individual's part.

The upshot is a **fractured system** that treats people differently solely based on how they obtain their insurance. Two neighbors could have similar family health needs and incomes, but if one gets coverage through a job and the other buys it themselves, their costs and experiences might be worlds apart. The one with employer insurance effectively gets an invisible government subsidy (via tax exclusion) and a visible employer subsidy, likely pays less out-of-pocket, and may have a broader choice of providers. The other neighbor might get a subsidy from the government if their income is low enough for ACA credits, but if they earn above that threshold, they get no help at all – they're on their own in the individual market, paying full freight. For many middle-class self-employed or early retirees, this has been a harsh reality: they pay more for less, compared to their peers in corporate jobs. This dichotomy has only become more salient as the economy changes – with more gig workers, contractors, and entrepreneurs who don't have a traditional employer safety net, the cracks in the employer-based model loom larger.

Conclusion: The Unintended Empire of Employer Insurance

Looking back at the history, it's astounding how an improvised solution in wartime became the bedrock of American healthcare. What began as a clever workaround to skirt wage controls evolved into a massive tax-subsidized system that, by the 21st century, covers the majority of Americans. Every step of the way, when confronted with the flaws of tying health care to employment, **politicians and policymakers chose not to undo it, but to build upon it**. They patched holes (like Medicare for the elderly, COBRA for the between-jobs gap, HIPAA for moving between plans) and propped it up (with tax breaks, mandates, and regulations favoring group coverage). Even the Affordable Care Act, which fundamentally reformed many aspects of health insurance, ultimately reinforced employer-sponsored insurance as the main pillar.

This path was not preordained – it was the result of decisions, concessions, and sometimes inaction. By the 1960s, America could have pursued national health insurance as some countries did, or in later decades it could have shifted toward an individual-based private insurance system

with universal access. Instead, with each inflection point, the country essentially **doubled down** on the employer model. It was easier, politically and practically, to keep relying on companies to shoulder the burden of insuring workers (with government quietly subsidizing via tax policy) than to upheave the system. The unintended empire of employer insurance marched on.

The end result as we have it today is a sprawling, fragmented arrangement that can seem absurd from the outside. Your access to affordable health care often hinges on your job and what benefits your boss decides to offer. Those inside the walls of a good employer plan enjoy protections and pricing those outside can only wish for. It's a system that **broke many of the people it was supposed to benefit** – driving up costs, suppressing wages, locking individuals to jobs for fear of losing coverage – and yet is designed to keep itself that way through inertia and policy reinforcement.

As we move into the next chapter, we'll examine how our political leaders have grappled with this system in recent years. Spoiler alert: rather than fundamentally rethink the employer-based model, many have chosen to reinforce it even further, catering to those already advantaged by it while offering little more than lip service to those left out. In other words, they not only failed to fix this broken benefit – **they doubled down on it**. The consequences of that political choice continue to shape the lives of millions, and it's to that political history and its fallout that we turn next.

Key Takeaway

The reason ESI has survived every healthcare reform debate is simple: **both parties benefit from keeping it in place**. Until the public understands that this is not a free benefit—and that they are paying for it entirely out of their own compensation—there will be no political will to replace it with a fairer, more efficient system.

Chapter 6: Bipartisan Blindness – How Politicians Cemented the Crisis

Preserving a Broken System: The ACA and Employer Coverage

From the outset, the Affordable Care Act (ACA) was designed to **preserve employer-sponsored insurance (ESI)** rather than replace it. President Barack Obama explicitly rejected calls to end the employer-based system, arguing it would be too "radical" a disruption. In a 2009 address to Congress, he noted that **"on the right, there are those who argue that we should end employer-based systems and leave individuals to buy health insurance on their own,"** just as some on the left wanted single-payer, but **"either one would represent a radical shift that would disrupt the health care most people currently have"**. Instead, Obama said **"it makes more sense to build on what works and fix what doesn't, rather than try to build an entirely new system from scratch"**. In practice, "building on what works" meant **leaving the employer-based model intact**. The ACA famously reassured Americans: **"If you like the plan you have, you can keep it"**. This pledge underscored that the new law would not displace existing job-based coverage. Democratic leaders openly **stressed that the ACA built upon the work-based insurance system** already in place. Far from uprooting the status quo, the reform was grafted onto it – a deliberate choice that **preserved ESI's central role** in American health care.

The ACA's design decisions reflected this preservation of ESI. Rather than curtail the tax-free status of employer health benefits – that economists have long criticized for inflating costs – the law left it largely untouched. Instead of empowering individuals to easily purchase portable insurance outside the workplace, the ACA imposed an **"employer mandate"** (requiring larger firms to offer coverage or pay a penalty) that further cemented the link between jobs and insurance. The law did include a tax on high-cost employer plans (the so-called **"Cadillac tax"**), intended to *indirectly* check the most generous ESI benefits, but it delayed its own implementation and would later be repealed before ever taking effect because cost shot up so quickly almost every ESI plan would have been subject to the tax. In short, the signature health reform of 2010 **entrenched the employer-based model** – exactly as Obama had promised to do. What it did not do was **fundamentally fix the structural flaws of ESI**, setting the stage for the crisis to continue and accelerate.

Decades of Warnings Ignored: Cost Inflation and Wage Suppression

For **decades, economists and policy experts warned** that tying health insurance to employment – and especially the tax-free treatment of employer premiums – was fueling **unsustainable cost inflation and holding down workers' wages**. These warnings stretch back generations, yet politicians on both sides largely ignored them. Economists have long been nearly unanimous that

workers pay for employer health benefits through lower wages in the long run. In other words, **every dollar an employer spends on health premiums is a dollar not going into paychecks**. There is ample empirical evidence that rising benefit costs have suppressed wage growth. A recent analysis found that the average American family with job-based insurance **lost out on roughly $125,000 in earnings over the past 30 years** due to **health premiums eating into compensation**. Premiums have consistently grown faster than wages, meaning a bigger share of compensation is diverted to health insurance each year. The **"hidden cost"** of ESI has been massive: what employers pay in premiums ultimately comes out of workers' potential pay, contributing to wage stagnation and income inequality.

Not only did ESI squeeze wages, but it also **inflated health care costs** over time. Because employer premiums have been tax-exempt – a policy choice dating to World War II – both employers and workers have been insulated from the true cost, encouraging ever-more-generous coverage. Studies showed that this **tax exclusion led employers to offer more expansive, gold-plated plans**, driving up utilization and prices. Analysts warned of a **"medical arms race"**: since insurers (often negotiating on behalf of large employer groups) would generously reimburse providers, hospitals and doctors had incentive to expand services and raise prices, knowing the costs would be covered by third-party employer insurance. Over the years, experts across the political spectrum – from conservative think tanks to nonpartisan economists – **cautioned that ESI's structure was fueling runaway medical inflation** and encouraging inefficient use of health resources. In sum, the employer-based system was **driving costs upward while holding wages down**, a one-two punch to American workers' prosperity. These red flags were waved repeatedly in policy circles, yet when it came time to reform health care, politicians largely **turned a blind eye** to the root cause.

The ACA's Expensive Patchwork: Subsidies Instead of Structural Fixes

Rather than heed those warnings and tackle ESI's underlying flaws, the ACA applied a **costly patchwork of coverage expansions and subsidies** on top of the existing system. Lawmakers chose to **preserve the familiar employer-based framework** and focus on covering the uninsured through other means – chiefly, by expanding Medicaid and creating income-based subsidies for private insurance purchased on new exchanges. In doing so, they **transferred massive liabilities onto taxpayers** without addressing the health cost pressures emanating from ESI. The ACA's architects knew that leaving employer plans untouched meant continuing the inflating premiums and tax expenditures associated with them. Yet they calculated that a direct overhaul of employer benefits was politically impossible. The result was a compromise: keep ESI as-is, and create parallel government-funded channels to ensure those left out.

The price tag of this approach was enormous. The ACA's new subsidies and Medicaid expansion represented **one of the largest entitlement increases in decades**. Official ten-year cost estimates at the time hovered around $1 trillion, but that was misleadingly low due to budget gimmicks. Senator Judd Gregg warned in 2009 that once the ACA was fully phased in, **"when all this new spending occurs"** from 2014 onward, **the bill would cost $2.5 trillion over the first true decade**. Other analysts noted that much of the law's cost was hidden off the federal

books – for example, the **individual and employer mandates forcing private spending** – and argued the real price over ten years of implementation could exceed **$6 trillion**. Regardless of the exact figure, the ACA undeniably created a vast new public spending commitment. Taxpayers were now on the hook for subsidizing millions of people's coverage – **pouring federal dollars into a system that remained structurally broken**.

Crucially, the ACA **failed to reform the fundamental incentive problem** with ESI. The law did include the Cadillac tax provision (an excise tax on high-cost employer plans) as a nod to cost control, but this was a politically tenuous measure from the start. Its implementation was delayed repeatedly amid outcry from unions and employers, and ultimately **Congress repealed the Cadillac tax entirely** before it ever took effect. In the meantime, nothing in the ACA stopped the continued **escalation of employer plan premiums**, which the government implicitly subsidizes through the tax code. In fact, by expanding coverage without robust cost containment, the ACA arguably **pumped more fuel into the inflationary fire** – increasing demand for health services (through newly insured individuals) while the supply side and pricing distortions were largely unaddressed. The outcome was a dramatic expansion of health insurance coverage (the uninsured rate plummeted), but at the cost of **vast public expenditures** and **entrenchment of the existing ESI-centric market**. The structural problems – cost inflation and wage trade-offs – persisted under the surface, now buoyed by government funding.

Doubling Down: Bipartisan Entrenchment of Employer-Based Insurance

It was not only Democrats who cemented this structurally unsound system – **Republicans have been equally complicit** over the years, making this a truly bipartisan failure. GOP politicians vigorously opposed the ACA's spending and regulatory overreach, but **not because it left the employer model in place**. In fact, when Republican leaders had opportunities to reform health care, they largely **shied away from confronting ESI's distortions** as well. For example, Senator John McCain's 2008 presidential campaign was a rare instance where a major politician dared to propose ending the tax exclusion for employer health benefits in favor of a flat tax credit for all. McCain's idea would have fundamentally shifted insurance ownership from employers to individuals. **The reaction was telling**: Barack Obama (then a candidate) attacked McCain's plan as **"radical"** and warned it would *"make you pay income tax on your health insurance benefits…taxing health benefits for the first time ever"*, predicting employers would drop coverage in masse. The political firestorm helped sink any chance of reforming the tax exclusion at that time. After that episode, few politicians in either party have dared suggest taxing employer benefits again. (Notably, President Obama's own spokesmen quietly acknowledged after the election that **some tax on employer plans might be necessary** to fund the ACA, a **flip-flop** from the campaign rhetoric, but in the end the indirect Cadillac tax was the chosen approach – one that would later be undone.)

When Republicans later controlled Congress, their "repeal and replace" efforts for Obamacare **left the employer-based structure largely untouched**. The GOP's 2017 proposals focused on cutting Medicaid and exchange subsidies, repealing mandates, and reducing insurance regulations – but **did not eliminate the core tax exclusion for ESI** or transition Americans

away from job-tied coverage. House Speaker Paul Ryan, a prominent Republican policy voice, had long acknowledged that **"at the heart of the problem is the federal tax exclusion for employer-provided health coverage"** and argued that **"ownership of health insurance must be shifted away from third parties to those who are actually using it"**. Yet, this insight from Ryan's 2010 roadmap never translated into bold legislative action when the GOP had power. In practice, Republicans too **doubled down on the existing model** – focusing on deregulation around the edges while **leaving the fundamental ESI framework in place**. There was no serious effort to equalize tax treatment between employer plans and individual plans (something many conservative economists advocate). Even **Ryan's own health reform blueprint** during the 2016 campaign ended up emphasizing tax credits *alongside* the current exclusion, rather than replacing it outright. The political risk of altering ESI was evidently too great.

The most glaring example of bipartisan entrenchment came with the fate of the Cadillac tax. This provision had been one of the few structural cost controls in the ACA – a way to **discourage overly generous, high-cost employer plans** by taxing them above a certain threshold. However, as implementation neared, **both parties in Congress joined forces to kill it**. In July 2019, the House of Representatives voted **419–6** to repeal the Cadillac tax entirely – an overwhelming bipartisan consensus. The Senate soon followed with a companion bill backed by 60 cosponsors *equally divided between Republicans and Democrats*. Lawmakers of both parties celebrated the removal of this tax on employer plans, disregarding the fact that it had been included to rein in long-term costs. In voiding the Cadillac tax, Congress forfeited an estimated **$197 billion in revenue over the next decade** – money that will now effectively continue subsidizing expensive employer insurance premiums. The repeal was hailed as a victory by interest groups from **unions to business lobbies**, eager to maintain the tax-free perk of lavish health benefits. But the result was **to further entrench the ESI status quo**, showing that when push comes to shove, **politicians of both parties prioritize short-term political comfort over structural reform**. As a bipartisan group of Senators wrote triumphantly, the goal was to *"protect the current tax treatment of employer-provided coverage"*, reflecting a broad **alignment in preserving ESI's privileged position**.

The cumulative effect of these choices has been **trillions in costs and a structurally broken market left firmly in place**. By preserving employer-sponsored insurance at all costs, lawmakers avoided disrupting how most Americans get their coverage – but **at the expense of higher costs, depressed wages, and massive government liabilities**. The tax exclusion for ESI remains one of the largest subsidies in the federal budget (worth over $300 billion per year), a benefit so politically sacrosanct that neither party will touch it. The ACA layered additional subsidies on top of this, rather than replacing it, meaning we now subsidize health insurance twice: once indirectly through lost tax revenue on employer plans, and again directly through public programs and credits. **Warnings about the long-run unsustainability** of this approach – from budget watchdogs, economists, even some far-sighted politicians – have gone unheeded. The "benefit that broke you," employer-sponsored health insurance, continues to dominate, **propped up by policy decisions that both Democrats and Republicans have justified**. In the end, this **bipartisan blindness** has cemented a health care crisis where costs keep climbing, wages stay stagnant, and taxpayers are on the hook for an ever-growing tab. As one observer quipped, *"If you think health care is expensive now – just wait until it's free"*. Lawmakers of

both parties have so far lived up to that cynical proverb, choosing to **double down on a failing system** and leaving truly transformative reforms for the next generation to finally confront.

Sources: The historical and economic analyses are supported by numerous expert sources. President Obama's 2009 address to Congress outlined the ACA's philosophy of building on the employer-based system rather than replacing it. Contemporary fact-checks confirm that Democratic leaders touted the ACA as an extension of work-based coverage, not a government takeover. Economists' near-unanimous view that ESI costs come out of workers' wages is documented in health policy research, and recent studies quantify how rising premiums have suppressed wage growth over decades. Warnings about the tax exclusion fueling cost inflation and a "medical arms race" appear in policy analyses. ACA's fiscal impact has been debated, with critics like Sen. Judd Gregg and the Cato Institute highlighting multi-trillion-dollar cost projections once the law's provisions fully ramp up. Statements from Republican figures such as Paul Ryan emphasize the known problems of the employer-based model, even as GOP health bills left that model intact. Finally, the bipartisan repeal of the Cadillac tax in 2019 – by a 419–6 House vote – exemplifies how both parties chose to **remove** a constraint on ESI rather than enforce it, foregoing nearly $200 billion in projected revenues. All these sources collectively illustrate how **politicians cemented the crisis** by perpetuating a costly, inflationary employer-based insurance system instead of fixing its structural flaws.

Key Takeaway

The ACA's structural flaws are not an accident—they are the product of bipartisan decisions to preserve ESI and maintain industry revenue. When given multiple opportunities to reform the system, both parties chose the same path: **protect the status quo, protect the donors, and let the costs fall on taxpayers and workers.**

Chapter 7: Why We Can't Trust Politicians from Either Party

Both Parties Back the Status Quo — and It's Costing Us Trillions

Section 1: The Illusion of Reform and the Reality of Rot

The American healthcare crisis isn't the result of inaction — it's the result of **deliberate political choices**, made over decades, by both Democrats and Republicans. Politicians from both parties have promised reform, protection, and affordability. What they've actually delivered is **a rigged system that enriches insurers, burdens taxpayers, and strips financial security from millions of working Americans.**

Whether wrapped in the language of universal coverage or personal responsibility, the outcome has been the same: a healthcare financing structure **dominated by employer-sponsored insurance (ESI)**, inflated by subsidies, and increasingly held together by bailouts and empty promises. The public is told they're being helped — but behind the scenes, trillions are quietly handed to the insurance industry through tax exclusions, subsidies, and regulatory monopolies.

This chapter isn't about partisanship. It's about **bipartisan failure**.

- **Democrats** passed the Affordable Care Act (ACA), a law that **preserved and subsidized the employer model**, while destroying competition in the individual market.
- **Republicans** campaigned on repeal, but when given power, they caved — offering no structural reforms and failing to roll back even the most damaging provisions.

The result? A healthcare system that is **fiscally unsustainable, structurally broken, and morally indefensible**.

And the cost is rising. Consider the ACA subsidy expansions enacted during COVID — now set to expire in **January 2026**. Millions of Americans will lose coverage overnight when these subsidies vanish, exposing the brutal reality: **this system only "works" when taxpayers are writing emergency checks.**

The blame isn't red or blue — it's structural. And it's time to expose it.

Section 2: Democratic Leadership – Expanding the Trap

Barack Obama: The False Promise of "If You Like Your Plan…"

President Obama repeatedly promised that the ACA would reduce costs and let people keep the coverage they had. Instead, it destroyed the individual market, tripled premiums in many states, and handed insurers permanent federal subsidies. Obama's team knew employer-sponsored

insurance was the root cause of cost distortion — yet chose to **cement it** with an employer mandate, new benefit mandates, and even more tax favoritism.

His promise that "the average family will save $2,500" was never realized. In reality, premiums soared, and deductibles ballooned. Millions lost the plans they had when ACA-compliant mandates rendered their coverage illegal. Obama's legacy wasn't cost control — it was the **institutionalization of ESI dependence**, and a shift from individual choice to taxpayer-funded insurance cartels.

Nancy Pelosi: "We Have to Pass the Bill…"

Speaker Pelosi was instrumental in passing the ACA, infamously telling reporters, "We have to pass the bill so you can find out what's in it." What was in it, as it turned out, was a blank check to the insurance industry.

Pelosi claimed the law would reduce premiums and save money. But by favoring income-based subsidies over portable, market-driven solutions, the ACA **distorted incentives, inflated coverage costs**, and entrenched employer power. Pelosi later celebrated the ACA's success in "expanding coverage" — yet much of that expansion was **Medicaid welfare enrollment**, not true insurance. The individual market was obliterated, and the employer market got stronger — with no accountability for the trillions that followed.

Joe Biden: Cementing ESI, Banning Competition

As Vice President, Biden was a cheerleader for the ACA. As President, he doubled down — **expanding subsidies**, pushing ACA enrollment to record highs, and **banning short-term health plans** that had become the last affordable private alternative for unsubsidized individuals.

In 2024, his administration finalized rules to limit short-term plans to just three months. These plans were never meant to replace comprehensive coverage, but they offered an escape from the overpriced ACA market for millions of Americans who earned too much for subsidies. By eliminating them, Biden **gave insurers a captive customer base** — and **further entrenched ESI by removing any competition** for portable, individually-owned plans.

Biden's crowning ACA expansion — the "big beautiful bill" of COVID-era subsidies — is set to **expire in January 2026**, stripping coverage from millions of Americans and proving once again that the system only "works" with emergency taxpayer bailouts. There is **no structural sustainability**, just more political duct tape.

Chuck Schumer: Celebrating Subsidies as Cost Savings

Senate Majority Leader Chuck Schumer repeatedly touted the ACA as a cost-control success. He claimed premiums were lower and growth had slowed — ignoring the reality that subsidies merely masked rising costs and **shifted the burden to taxpayers**.

Schumer supported the ban on short-term plans, cheered the expansion of federal assistance, and offered no alternative to the employer-based system. His stance helped preserve a two-tiered world where Americans without access to ESI are stuck paying $3,000+ per month for ACA coverage — or going uninsured. Schumer's loyalty to the subsidy pipeline speaks volumes about where power lies in Washington: **not with consumers, but with carriers.**

Section 3: Republican Leadership – Rhetoric Without Reform

Joni Ernst: "Make Them Squeal" (Then Do Nothing)

In 2014, Iowa Senator Joni Ernst ran a viral campaign ad promising to "castrate Washington" and repeal Obamacare. Once elected, she voted for repeal bills — but **never offered a replacement**. Her repeal-only votes would have stripped protections and coverage without any alternative structure to transition families.

She claimed to oppose government waste, but **did nothing to address the tax exclusion for employer plans**, the single largest hidden entitlement in the federal budget. Her tough talk faded fast, replaced by inaction and complicity in maintaining the very system she campaigned against.

Ron DeSantis: Undermining the Only Viable Reform

As a Congressman in 2017, Ron DeSantis had a chance to back **age-based tax credits** — a major reform that would have begun shifting ownership of health coverage from employers to individuals. He refused.

DeSantis criticized HSAs as requiring "too many somersaults," and voted to protect the existing ESI model. His position helped kill the American Health Care Act, the only structured repeal-and-replace bill Republicans ever passed. Instead of backing a plan that could have weakened employer dominance, he **defended the system that drives inflation and dependence**.

Mitch McConnell: Symbolic Repeal, Structural Surrender

Senate Minority Leader Mitch McConnell spent years promising to repeal the ACA "root and branch." But when Republicans had full control of government, he failed to deliver a working alternative.

McConnell supported multiple repeal attempts with **no replacement strategy**, then helped repeal the **Cadillac Tax** — one of the few provisions that could have reined in gold-plated employer plans. His approach left the ACA intact, and by default, **entrenched employer insurance even deeper** into the U.S. system.

Rand Paul: Purity Over Progress

Senator Rand Paul opposed the GOP's replacement bill in 2017, calling it "Obamacare Lite." He refused to support age-based tax credits or incremental reforms because they didn't go far enough. His ideological rigidity **helped sink the bill**, killing the only serious attempt at transitioning to portable, market-based coverage.

In rejecting "half-measures," Paul ensured the full ACA remained — employer mandates, subsidies, and all. His stand for ideological purity **preserved the exact system he said he opposed**.

Marco Rubio: A Case Study in State-Level Failure

Florida Senator Marco Rubio railed against the ACA, yet failed to act when his own state wasted tens of millions on a failed health exchange. Under Rose MeGowen's leadership, the Florida exchange (Florida Health Choices) **enrolled fewer than 100 people**, despite paying MeGowen $174,000 a year and receiving millions in federal and state grants.

Rubio never investigated the waste. He never proposed a functioning alternative. And he never delivered on his promise to protect taxpayers from bureaucratic failure or ACA dependency. Florida's residents were funneled into ACA plans — the exact outcome Rubio claimed to oppose.

Section 4: The January 2026 Cliff — Proof of a System That Cannot Stand

Perhaps the most damning example of bipartisan failure is the looming coverage cliff in **January 2026**.

During the COVID-19 pandemic, Congress passed temporary expansions to ACA subsidies. These expansions reduced out-of-pocket premiums for millions, but **did nothing to fix the base cost of insurance.** They simply shifted even more of the bill to taxpayers — inflating insurer profits and hiding the real price tag.

Now those subsidies are set to expire. And when they do, **millions of people will lose coverage or face unaffordable premiums overnight.** Middle-class families will be priced out of ACA plans. Many will be left with no options — not because insurance became more expensive, but because **the politicians who built this system failed to make it viable without bailouts.**

It's hard to imagine a more vivid example of policy negligence. This wasn't an accident. It was the outcome of designing a system that only works when Congress writes trillion-dollar checks every few years to prevent collapse.

Section 5: A System Built to Fail — and a Political Class That Let It Happen

Employer-sponsored insurance was never a deliberate policy. It was an accident of history — born out of wartime wage controls and cemented by tax favoritism. Yet for nearly a century, politicians from both parties have treated it as sacred, **shielding it from reform while piling taxpayer money into its preservation**.

The result is a system that:

- Ties your health care to your job
- Suppresses your wages to fund overpriced benefits
- Funnels subsidies to insurers while claiming to help families
- Punishes anyone outside the ESI system with unaffordable premiums

Democrats call this "progress." Republicans call it "reform." But it's neither. It's a decades-long scam — **a transfer of wealth from workers and taxpayers to insurers and employers**, enabled by elected officials who either don't understand what they're protecting or don't care.

This chapter is not about blame. It's about **recognizing that both parties are responsible**, and that **real reform will never come from inside the current system**. The public must demand more than slogans. We must demand structural change.

Because if we don't — they will keep making us pay for it.

Key Takeaway

We can't trust politicians from either party to reform healthcare. They've had decades, multiple majorities, and countless opportunities. What they've done instead is protect the financial flows that benefit insurers, hospitals, drug makers, and large employers—while middle-class families and taxpayers foot the bill.

Chapter 8: A New Path – How Age-Based Tax Credits Work

The Simple, Voluntary Alternative That Ends Job Lock, Saves Trillions, and Restores True Insurance

The chapters leading up to this point have made one thing clear: the American health insurance system has been hijacked by employers, insurance companies, and politicians who all benefit from keeping you tethered to a job-based, inflationary, taxpayer-subsidized system. Employer-sponsored insurance (ESI) was never designed to be the backbone of U.S. healthcare. It became dominant by accident, and now survives through inertia, lobbying, and a tax code that hides its true cost.

But there is a better way — one that puts the consumer first, rewards personal ownership, and builds a portable, transparent, and affordable future. It doesn't require mandates, takeovers, or bureaucracy. And it doesn't need to dismantle ESI by force. It will end employer insurance voluntarily, as millions of Americans choose a better option.

That option is **age-based tax credits**.

Section 1: What Are Age-Based Tax Credits?

At its core, an age-based tax credit is **a fixed, refundable dollar amount the government provides each year to help you buy health insurance — based solely on your age, not your income or job status.** The older you are, the larger your credit — because older individuals tend to face higher health costs.

Unlike the ACA's income-based subsidies or employer-sponsored coverage (which is tax-exempt for some and entirely out of reach for others), **this model is flat, transparent, portable, and universal.** Every legal resident receives it. No one is penalized for earning more, working independently, or retiring early.

💵 **Example Credit Structure:**

Age	Annual Credit
0–30	$3,000
31–39	$3,100–$3,900
40–49	$4,000–$4,900
50–59	$5,000–$5,900
60–64	$6,000-$6,400

These are flexible credits — **refundable**, so you get the full amount even if you owe no taxes — and **use-it-or-save-it** credits: if you choose a less expensive plan, **the unused portion rolls into your Health Savings Account (HSA)** for future use.

Section 2: How It Works in Practice

Every year, you get your credit — let's say $3,500 for a healthy 35-year-old. You can use that credit to shop for any qualified plan in a **true open market** — not just a government exchange. You can choose:

- A low-premium catastrophic plan
- A high-deductible HSA-compatible plan
- A basic indemnity plan for large events
- A more comprehensive policy if you need it

Let's say you find a plan that costs $2,800 for the year. The leftover $1,200 goes directly into your personal **HSA** — tax-free and yours to keep. Those dollars grow every year, compounding into a long-term safety net for future care.

There's no employer "network." No COBRA cliff. No surprise change in your plan if you change jobs. You own it. You keep it. And the government support is clear, consistent, and **fair to everyone**, regardless of income or employment.

Section 3: Why Age-Based Beats Income-Based Subsidies

The current system of income-based subsidies, as used in the ACA, creates **perverse incentives** and massive administrative waste.

- If you earn too little, you're pushed into Medicaid.
- If you earn slightly more, you get a subsidy — but it fluctuates with your income.
- If you earn just a little too much, your premium **jumps by thousands of dollars overnight**.
- And if your income is irregular (like for gig workers, entrepreneurs, or seasonal workers), the system becomes a minefield of overpayments, clawbacks, and penalties.

This complexity discourages work, penalizes upward mobility, and forces people into dependency or gamesmanship. It also **eliminates predictability**, making health planning a nightmare.

Age-based credits fix this. They are:

Simple — You know what you're getting every year.
Stable — No penalty for earning more.
Universal — Every American gets support.
Portable — Use it with any plan, anywhere.
Transparent — No hidden costs, no paperwork trapdoors.

Section 4: Voluntary Opt-Out – Why This Model Doesn't Require a Mandate

This system is not coercive. No one is forced to abandon ESI, Medicare, or ACA coverage. Instead, the age-based credit gives every individual a **standing option** to opt out of their current plan and take control.

And here's the beauty: **employer-sponsored insurance will unravel on its own — voluntarily.**

How? Because the people who prop up ESI — the young, healthy, low-risk workers — will be the first to leave. A 28-year-old worker today may be "paying" $7,000 per year in hidden premium value through lost wages, only to get coverage they barely use and can't keep if they leave the job.

But if that same 28-year-old can take a $3,000 credit and buy a $2,000 catastrophic plan — and bank the other $1,000 in their HSA — they'll do it. And when enough people start making that decision, **employers will start dropping their coverage**, too. They'll offer cash instead — which employees prefer — and let people use their credits freely.

It's not a revolution. It's **a natural migration to freedom.**

Section 5: What Happens to Medicaid, ACA, and ESI?

This system doesn't abolish Medicaid or the ACA overnight — it renders them **increasingly obsolete** as people opt out.

- **Medicaid**: Not every person on Medicaid is chronically ill. Many are healthy children, working adults, or pregnant women. For these groups, the age-based credit (especially paired with HSA contributions) can offer **better, portable, and dignified alternatives**. Medicaid can then return to its core mission: covering the truly needy with complex medical conditions.
- **ACA**: With flat credits available to everyone, the ACA's income-based subsidies become irrelevant. No need for complex enrollment, claw backs, or verification. The exchanges may still exist, but they become **one marketplace among many**.
- **ESI**: As more people voluntarily leave, employers will begin shifting from offering coverage to **providing direct pay increases or defined contributions** toward any plan

the employee chooses. This liberates businesses from administrative overhead and wage distortion, and helps restore **true competition and wage transparency**.

Section 6: The HSA Advantage – Saving for the Future, Not Just Paying for the Present

One of the greatest failings of the current system is that it treats health insurance as a pass-through — money goes in, claims go out, and the insurer always takes a cut.

Under the age-based model, **any unused credit can go into your personal Health Savings Account (HSA)** — where it grows, compounds, and rolls over year after year.

- A healthy 30-year-old who saves just $1,000 a year from unused credits could have **$40,000–$60,000** by the time they're 60.
- That money can be used tax-free for future medical expenses — surgeries, dental care, vision, long-term care, or Medicare premiums.
- Unlike current flexible spending accounts (FSAs), there's no "use it or lose it." This is **real wealth**, tied to your health future.

This feature turns insurance from a short-term expense into a **long-term savings strategy** — helping younger Americans build assets instead of handing those dollars to an insurer they'll never meet.

Section 7: Trillions in Savings — and a System That Finally Works

The age-based model doesn't just help individuals. It helps the entire economy. By allowing people to opt out of ESI and overpriced ACA plans, the system begins to self-correct:

Trillions in federal tax savings

- Eliminating the income tax exclusion for ESI removes the single largest hidden subsidy in the federal budget (over $400 billion/year).
- Replacing income-based ACA subsidies with flat age-based credits is simpler, fairer, and cheaper.
- Medicaid enrollment shrinks over time as people transition to private coverage.

Employer savings

- Employers save thousands per worker by no longer administering plans or providing inflated benefits.
- That money returns to employees in the form of cash wages or 401(k)/HSA contributions.

Consumer freedom and transparency

- People shop for plans based on price, quality, and personal preference.
- Insurers are forced to compete on value, not hide behind network complexity.

Campaign finance disruption

- When health dollars no longer flow through insurer monopolies and employer HR departments, the political influence of insurance companies and hospital lobbyists shrinks dramatically.

The savings aren't theoretical — they're built into the design. As more people adopt this model, **ESI will disappear by choice**, not by force. And the system will be left with a **simple, voluntary, affordable foundation**: risk-based insurance, owned by the individual, funded transparently, and saved for the future.

Conclusion: The First Step Toward a Healthcare Revolution

Age-based tax credits are not a magic wand. They don't abolish the existing system overnight, and they don't require the government to nationalize care or force behavior.

What they offer is **a dignified exit ramp** — a way out of a distorted, unsustainable model that has cost us trillions and crushed millions of Americans under the weight of hidden premiums, suppressed wages, and bloated bureaucracy.

They restore what insurance was meant to be: **a shield against catastrophe**, not a prepayment plan for expected expenses. They empower people to choose, to save, and to own their future.

The politicians won't fix this. The lobbyists will fight it. But the people — if given the chance — will walk away from the broken system on their own.

And when they do, we'll finally have a health care framework that serves patients, not politics.

Key Takeaway

Age-Based Tax Credits are the off-ramp from ESI that politicians have never given us. They're voluntary, portable, and designed to let the system unwind on its own—without waiting for Congress to find political courage. By putting the money in the hands of individuals, ABTCs break the revenue chain that fuels runaway costs and finally give Americans ownership of their healthcare.

Chapter 9: Medicare's MSA: The Blueprint for Age-Based Tax Credits

Health reform ideas can often sound radical or untested—until we realize that a successful precedent might already exist. In this chapter, we focus on **Medicare's Medical Savings Account (MSA) plan** as a blueprint for the age-based health insurance tax credits we are proposing. The Medicare MSA program combines a high-deductible Medicare Advantage insurance plan with a special savings account funded by Medicare. This structure is essentially a **defined-contribution model** within Medicare, and it closely mirrors the age-based tax credit approach we envision for all age groups. By examining how the Medicare MSA works and why it was implemented, we can see that our proposal isn't starting from scratch at all – it's building on a proven concept.

How the Medicare MSA Plan Works

Medicare's MSA plans (a type of Medicare Advantage Part C option) pair a **high-deductible health insurance plan** with a **medical savings account** for the beneficiary. Here's how it operates in practice:

- **Fixed yearly contribution:** Medicare pays a set amount of money to a private insurance company for each MSA plan enrollee. The plan then **deposits a portion of that money into the individual's Medical Savings Account** at the start of the year. This is essentially "seed money" to help cover healthcare expenses until the deductible is met.
- **High deductible coverage:** The insurance component is a high-deductible plan that **kicks in only after the beneficiary has paid the deductible amount out-of-pocket**. For example, one nationwide MSA plan in recent years has a $5,000 annual deductible; once an enrollee spends $5,000, the plan covers 100% of further Medicare-approved charges for the year.
- **Using the savings account:** The **Medicare-funded savings account** is there to help pay for medical costs before the deductible. Enrollees can use the deposited funds to pay for any qualified medical expenses, including those not covered by Medicare, tax-free. If they prefer, they can pay out-of-pocket and let the account money grow for future needs – it's their choice how to manage it.
- **No monthly plan premium:** MSA plans typically charge *no additional premium* for the insurance itself (beyond the standard Medicare Part B premium all Medicare enrollees pay). Medicare's contribution covers the cost of the high-deductible policy, so the beneficiary isn't paying extra for coverage.
- **Rollover incentive:** Crucially, **any money left in the MSA at year's end rolls over** and remains in the account for future healthcare expenses. The next year, Medicare makes a new deposit, adding to whatever funds were unspent from the previous year. Over time, a person who stays relatively healthy can accumulate significant savings. For instance, in the plan with a $5,000 deductible, Medicare deposits $2,000 each year into the MSA; if the enrollee spends only $500 of it in a year, the remaining $1,500 carries forward, and

another $2,000 is added the next year. This effectively **rewards cost-conscious healthcare decisions** by letting beneficiaries keep (and grow) the unused funds.

In summary, the Medicare MSA plan gives beneficiaries a fixed annual healthcare contribution and full catastrophic coverage after a high deductible. If patients manage their care costs below the contribution amount, **they keep the leftover funds in their account** – just like how under an employer's HSA plan or a personal savings account, unspent dollars remain yours. This model turns patients into savvy consumers: since they directly benefit from shopping for cost-effective care, they have an incentive to avoid wasteful spending. Yet, they still have the peace of mind that if an expensive illness or accident occurs, the insurance will cover all costs above the deductible. It's a blend of personal responsibility and financial protection.

A Legislative Precedent for Our Proposal

One reason we call the Medicare MSA **a blueprint** is that it's already established in law and has been functioning within Medicare for years. The idea of consumer-directed Medicare plans was introduced on a trial basis in the late 1990s and then written into permanent law in the early 2000s. A short history is instructive:

- **1997: Demonstration program.** Congress first authorized Medicare MSAs as a limited demonstration in the Balanced Budget Act of 1997. The goal was to test whether giving seniors a defined contribution and more control over spending could reduce costs while maintaining coverage.
- **2003: Made permanent.** The Medicare Modernization Act of 2003 (the same law that created Part D prescription drug coverage) made MSA plans a permanent option within Medicare. Lawmakers saw enough promise in the consumer-directed approach to extend it beyond a demonstration.
- **2007: Plans available to beneficiaries.** It took a few years for insurance carriers to start offering MSA plans, but by 2007 the first Medicare MSA plans became available for enrollment. In fact, **the very first Medicare MSA plan sold in the United States was implemented by one of this book's authors, Lee Benham, in 2007**. As an insurance broker, Lee was on the front lines, helping a Medicare beneficiary enroll in this new type of plan. His pioneering involvement gave him firsthand insight into how the MSA model worked for real patients.
- **Growth of the program.** Medicare MSA plans initially rolled out slowly, but they expanded over time. As of 2023, one insurer (Lasso Healthcare) offered an MSA plan in 35 states. Millions of seniors had access to these plans, which can save an average enrollee up to around $3,000 per year compared to traditional Medicare out-of-pocket costs. While MSA plans remain a relatively small niche within Medicare Advantage, with only one state still having access to them (Wisconsin) their track record proves that the concept can work on a larger scale when properly implemented.

This history is important because it shows **our reform isn't an untested theory** – it is built on the same principles that Congress has already enacted within Medicare. If a defined-contribution MSA model can work for seniors on Medicare, why not adapt and expand it to the rest of the population? The legislative precedent of the Medicare MSA indicates that both political parties

can find common ground on this approach. (Notably, the 2003 law that cemented MSAs was a bipartisan effort.) By pointing to the MSA in Medicare, we can demonstrate to policymakers and the public that **legislation similar to what we propose **already exists** within the healthcare system. This blueprint can guide the drafting of new laws to extend the approach beyond Medicare.

From Defined Benefit to Defined Contribution in Healthcare

At its heart, the MSA concept represents a shift from the traditional "defined benefit" model of health coverage to a "defined contribution" model. Understanding this shift is key to appreciating why the Medicare MSA is the foundation for our age-based tax credit proposal.

- **Defined benefit healthcare programs** (like original Medicare, Medicaid, employer health benefits, and even ACA subsidies) commit the government or insurer to providing a certain set of benefits, whatever they end up costing. Essentially, the payer (taxpayers or employers) is on the hook for all medical expenses that meet the coverage criteria. There is no explicit cap on spending per person; if costs skyrocket, the program must somehow cover them. This is analogous to a traditional pension in the retirement world, where a company promises a certain retirement income (benefit) and must find the money to pay it, no matter how investment or cost factors turn out.
- **Defined contribution healthcare** flips that model. Instead of guaranteeing specific benefits, the payer commits to giving each person a **fixed contribution** (in dollars) toward purchasing health coverage, and the individual can choose how to spend that money. Once the contribution is used, any extra cost is the individual's responsibility (often buffered by catastrophic insurance). This is analogous to a 401(k) retirement plan: the employer (or government) contributes a set amount and the individual takes ownership of how it's used and invested. The risk of spending more than the contribution (and the rewards of spending less) lie with the individual, not the payer.

The Medicare MSA is a clear example of a defined contribution approach. Medicare gives each MSA enrollee a fixed deposit (e.g. $2,000) and covers a defined high-deductible insurance plan for them, instead of the open-ended commitment of paying every claim from the first dollar. The individual then manages that $2,000 account to cover routine care and has coverage if costs exceed $5,000 deductible. Medicare's financial exposure is essentially "defined" and capped: it provides the deposit and the plan coverage up to a limit, but if the person's costs are lower, Medicare doesn't pay more – the individual simply keeps the difference.

Our proposed age-based tax credit system adopts this same defined contribution philosophy. Rather than the government promising to pay whatever healthcare bills come in (as in Medicaid or subsidized employer plans), the government would **give each person a contribution (a tax credit) of a set amount based on age**, which that person would then use to obtain insurance and fund medical expenses. It's a controlled, budget able commitment from the government, coupled with enhanced choice and responsibility for individuals. By transitioning healthcare financing to a defined contribution basis, we can encourage efficiency and cost-awareness, much as 401(k) plans did in the retirement sector by making employees more engaged in saving and investing.

This shift is not just a theoretical musing – it is **already happening within Medicare via the MSA option**, and it has been embraced as a way to modernize healthcare. As Lee Benham put it in announcing his plan, "The Medicare MSA is the blueprint to solving our national health care problem". It exemplifies how a defined contribution can work in practice and why expanding that approach could transform healthcare nationally.

The Medicare MSA as a Blueprint for Age-Based Tax Credits

Using the Medicare MSA structure as our guide, we propose to extend a similar model throughout the healthcare system, especially for Americans under 65 who aren't yet on Medicare. The core idea is straightforward: **provide government funds in the form of age-based tax credits to every individual to obtain their own personal health insurance, with any leftover funds going into a savings account for medical expenses**. This would effectively give all Americans access to the same type of arrangement that Medicare MSA enrollees enjoy, scaled according to age-related needs.

Let's break down how our **age-based tax credit** proposal parallels the Medicare MSA blueprint:

- **Government contribution:** In Medicare MSA, Medicare contributes a fixed dollar amount for each beneficiary's coverage (via plan payment and account deposit). Under our plan, the federal government would similarly allocate a **fixed dollar tax credit for each person, varying by age group**. Younger people would get a smaller credit (because their expected healthcare costs are lower on average), and older people would get a larger credit to reflect higher expected costs. For example, a proposed structure might give around a **$3,000 annual credit for a child**, about **$4,000 for a young adult**, scaling up to **$6,000 for those in their 50s and early 60s**. Seniors 65 and over could also opt into a similar defined contribution system – in the Medicare MSA model today they effectively do, but this could be expanded or adjusted allowing saved has funds to transfer to Medicare MSA accounts.). These figures are illustrative, but they are grounded in current average spending for each age bracket.
- **Purchasing insurance:** With the tax credit in hand, an individual would **purchase a private health insurance plan of their choice** – ideally a high-deductible plan paired with a savings account, much like the Medicare MSA requires. The key is that **the choice of plan is up to the consumer** (any licensed insurer's offering that meets basic standards), making the insurance market **truly competitive and consumer-driven**. This parallels Medicare Advantage MSA, where beneficiaries can choose any provider or service since there's no restrictive network. Our system would empower people to shop for the best value with their credit.
- **Savings account for leftover funds:** Just as the Medicare MSA deposit goes into an account that the enrollee controls, our age-based credit system would allow any unused portion of the credit to flow into the individual's **personal Medical Savings Account (or Health Savings Account)**. If someone finds an efficient plan that costs less than their credit, the remaining dollars aren't lost or returned to the Treasury – they go to the person's **own savings, to be used for out-of-pocket medical expenses or saved for the**

future. For example, suppose a 30-year-old gets a $3,000 credit and buys a plan that costs $2,000; the extra $1,000 would end up in that person's medical savings account, growing tax-free for future needs. This mirrors exactly what happens in Medicare MSA plans: Medicare pays the premium and deposit; if the deposit isn't fully used, it remains in the account for the enrollee.

- **Personal responsibility and reward:** Under our blueprint, individuals would face similar incentives as Medicare MSA enrollees. They would want to spend wisely because **any unspent money is their gain**, not an insurer's or the government's. At the same time, they'd have security against catastrophic costs because the insurance plan (funded by the credit) covers large expenses after the deductible. It's a balance of **cost-conscious behavior with a safety net**, which is exactly what the MSA approach achieves in Medicare. This alignment of incentives could help slow healthcare cost growth by eliminating the blank-check effect of third-party payment. Patients become value-seeking consumers when they have skin in the game and a chance to benefit from prudent choices.
- **Universality and fairness:** Basing the credit on age is a way to distribute funds **more fairly and predictably than the current patchwork of subsidies**. Age is a major determinant of expected healthcare costs, so an age-adjusted credit ensures that older individuals get more assistance (as they typically need it), while younger ones get less (and are naturally cheaper to insure). This approach avoids some of the complexity and unintended consequences of income-based subsidies or employer-based benefits. It is transparent and easy for people to understand what they receive. Notably, it mirrors how Medicare itself budgets more for older seniors than younger (in Medicare Advantage, for instance, the payments to plans are higher for older enrollees due to risk scores). Our plan essentially says: let's take the concept behind **Medicare's contribution strategy and apply it to everyone, in advance, through tax credits**.

By using the Medicare MSA as our template, we address a common concern: *How do we know an age-based credit system with HSAs will work?* We know because **it already works within Medicare**. The government can indeed deposit a set amount for healthcare and let individuals manage part of their care with that money –thousands of Medicare beneficiaries have done so successfully. We're simply extending that mechanism to the broader population in a tailored way.

It's also worth noting that this kind of system can attract **bipartisan support**. Conservatives appreciate the increased individual responsibility, market competition, and potential for reducing government expenditure. Liberals can acknowledge that everyone is guaranteed a basic contribution toward coverage (universal financial assistance), and those who need more (e.g. the very sick) still have full coverage after the deductible – plus lower-income folks could receive supplemental assistance if needed on top of the base credit. In fact, by capping the government's exposure per person while still funding the credit for all, we create a sustainable path that controls federal spending but does not abandon people to lack of coverage. This balanced approach is why we call it a **"blueprint for bipartisan reform."** It takes the best of both worlds: government ensures everyone has help buying insurance, yet harnesses free-market principles to drive efficiency. The best part is if everyone had this plan in place today it would be a few trillion dollars cheaper than what we are currently doing.

Benefits of the Age-Based Tax Credit System

Adopting an age-based tax credit system modeled like the Medicare MSA yields numerous advantages. These benefits aren't just theoretical – they're borne out by what we've observed with the Medicare MSA and related consumer-directed health plans:

- **Significant cost savings:** By moving to a defined contribution, the government can better contain its healthcare expenditures. Instead of writing a blank check, it writes a fixed check for each person. The **total cost becomes predictable and capped.** In fact, preliminary estimates of our proposal suggest that if implemented nationally, it could **save over a trillion dollars in healthcare spending each year** compared to current trends. The press release announcing this blueprint calculated a total annual cost around $2.5 trillion for the credits (covering the entire population) versus roughly $4.5 trillion in current healthcare spending. While one can debate the exact figures, the direction is clear: there are enormous potential savings by eliminating inefficiencies, overhead, and over-utilization that plague the open-ended payment systems.
- **Lower premiums and greater choice:** When millions of individuals shop for insurance with their credit, insurers will compete to offer better value plans at lower prices, knowing that consumers will gravitate towards plans that let them retain more of their credit in savings. This competitive pressure can drive innovation in plan design and provider networks to keep premiums affordable. We've seen analogous effects in Medicare Advantage and Part D plans where beneficiaries comparing options leads to cost-conscious bidding by insurers. Moreover, **each person can choose the plan that best fits their needs** – whether a lean high-deductible policy or one with more bells and whistles (they might pay part of the premium if it exceeds the credit). The key is **choice**, in contrast to one-size-fits-all public programs or employer plans.
- **Personal savings and wealth accumulation:** One often overlooked benefit of the MSA approach is that individuals can build up substantial savings over time if they remain relatively healthy. The money that goes unspent in their account isn't a use-it-or-lose-it proposition; it's **their asset**, invested and growing for future medical needs. Under our age-based credit plan, a person who consistently spends less than the credit could accumulate tens or even hundreds of thousands of dollars over decades. For example, one projection showed that an average American who has an MSA from childhood to age 65 could accumulate around **$250,000** by retirement, and a healthier-than-average individual could amass over **$1 million** in their account. This is money they would carry into Medicare years, providing extra cushions for long-term care or other expenses. In essence, we'd be turning healthcare into a vehicle for *saving*, not just spending. Instead of premiums disappearing into an insurance company's coffers or taxpayer dollars vanishing into the healthcare bureaucracy, a portion of those funds stay with the individual as **personal savings**. This is a profound shift: health financing doubles as wealth building.
- **Incentive for healthier behavior:** When people directly benefit financially from prudent healthcare choices, they have more reason to engage in preventive care, shop for better prices on procedures, and avoid unnecessary or low-value services. The Medicare MSA already shows that when patients have control over dollars, they become more discerning. Over time, this could lead to a more **health-conscious society**, because the savings from healthy living don't just abstractly go to an insurer or the government – they end up in

one's own pocket. While our plan doesn't deny care to anyone, it does say: if you can avoid that $1,000 ER visit by managing a condition better, that $1,000 remains **your money** (in your MSA). That's a powerful motivator for personal responsibility and could bend the cost curve as healthier lifestyles and cost-aware decisions proliferate.

- **Simplification and transparency:** An age-based credit system is easy to understand. Every year (or every month), you get a certain credit amount to apply to health coverage. It's visible and tangible. Contrast that with today's convoluted arrangements: premiums partly hidden in paychecks, government subsidies calculated via complex formulas on your tax return, varying by income and region, etc. Our approach simplifies things to a straightforward benefit that everyone gets in an age tier. This transparency can improve public support and awareness of what healthcare actually costs. It also simplifies administration: rather than managing an open-ended entitlement, the government processes a fixed credit (potentially through the IRS or a benefits card system) – much simpler than the claims-paying apparatus of traditional programs.

In short, the Medicare MSA blueprint promises a **more sustainable, empowering, and efficient healthcare system**. By capping costs and engaging consumers, it tackles the root causes of high healthcare spending. By allowing savings rollovers, it turns healthcare funding into a long-term asset for families. And by basing contributions on age in a universal way, it creates a fair and understandable system where everyone has access to coverage funds, regardless of employment or income, while recognizing that a 60-year-old needs more assistance than a 20-year-old.

Lee Benham and Ron Greiner's Role in Advancing the MSA Blueprint

Before concluding this chapter, it's appropriate to acknowledge the contributions of **Lee Benham and Ron Greiner** as not only authors of this book and architects of the proposals herein, but also as a true pioneers in the field of Medical Savings Accounts. Their professional journey uniquely positions them to speak on this topic. As noted earlier, Lee was **the first insurance agent to ever sell a Medicare MSA plan** when they became available in 2007. Ron in contrast was the first agent to sell a MSA plan that latter became HAS plans today. The concept of combining a high-deductible health plan with a savings account was entirely new to consumers. Lee and Ron educated the first beneficiaries about how the plans worked, guided them through enrollment, and witnessed firsthand the positive outcomes of the experiment.

Having been *in the trenches* with MSAs from the very start, Lee and Ron have spent years refining the idea of using MSAs to reform healthcare. They have advocated that the **MSA model could be scaled up beyond Medicare** to address the broader system's issues. In developing the age-based tax credit proposal at the center of this book, They drew heavily on that real-world experience. In fact, one could say this entire proposal is the **culmination of Their career's work** – taking an innovation that benefitted a relatively small group of Medicare beneficiaries and generalizing it to benefit all Americans. It's a testament to the adage that *big doors swing on little hinges*: the insights gained from a niche Medicare option have unlocked a blueprint for sweeping national reform.

Lee and Ron's early adoption of MSAs also means they have encountered and solved many of the practical questions skeptics might raise. How do you ensure people understand and effectively use their medical savings account? What if someone with an MSA plan gets very sick and spends through their deposit? (Answer: the insurance covers them after the deductible, just as intended.) How do providers react when patients pay directly from an account? (Often with more transparent pricing and willingness to offer discounts for cash payment.) These real-life lessons have informed the design of our age-based credit system to make it user-friendly and fail-safe. **Lee and Ron's pioneering work with MSAs** is living proof that Americans can handle having more choice and responsibility in healthcare – and that many will thrive under such a system.

In recognition of that, our blueprint for reform is often referred to as *"Lee and Ron's MSA Blueprint for Health Care Reform."* This isn't to seek personal accolades, but to underline that an industry expert who has walked the walk has crafted this plan. It lends credibility and tangible experience to what might otherwise sound like an abstract theory. As we move into the next chapters, which detail how exactly we can implement age-based tax credits and MSAs on a national scale, keep in mind that **the foundation is already laid**. We have the blueprint in Medicare, and we have the architects in our midst.

Conclusion

The Medicare MSA may once have been considered a small pilot program or even a footnote in the vast Medicare program, but today it stands as a shining example of what *could* be the future of American healthcare financing. It demonstrates that giving individuals a defined contribution and the freedom to manage their health spending can work – delivering both cost control and individual empowerment. In this chapter, we saw **why the Medicare MSA is the blueprint** for our age-based tax credit proposal: it has a proven track record, a solid legislative foundation, and a philosophy of consumer-directed care that transcends partisan divides.

By learning from and expanding upon Medicare's MSA, we can tackle some of our biggest challenges: unsustainable government spending, high insurance premiums, lack of portability, and inadequate savings for medical needs. The blueprint shows us a clear path to address these issues. In the chapters that follow, we will build on this foundation, describing how to implement age-adjusted credits, how to ensure a smooth transition from the old system to the new, and how to address the finer details (like ensuring the sick and the poor are protected). But the crucial takeaway from this discussion is one of **optimism**. We are not designing a solution in a vacuum – we are updating and broadening a solution that is *already out there*. Just as the MSA gave seniors more choice and savings, age-based tax credits can give every American financial control, security, and a stake in managing healthcare costs.

In essence, **the blueprint for age-based tax credits is already drawn within Medicare**. Now it's up to us to trace that blueprint onto the national canvas and color it in with bold reforms. The result could be a healthcare system that is fiscally sustainable, individually empowering, and fundamentally fair. That is the promise of the Medicare MSA model, and that is the promise of our proposed reform. It's time to take this blueprint and build the future of healthcare upon it.

Key Takeaway

The Medicare MSA is living proof that giving people direct control over their healthcare dollars works. It failed to gain traction not because it was flawed, but because it threatened the revenue model of insurers and providers. Age-Based Tax Credits can avoid this fate by aligning incentives, ensuring broad awareness, and making the transition voluntary—so the system unwinds naturally, without political force.

Chapter 10: How Political Incompetence Can Stifle a Bipartisan Consumer Driven Plan. Understand the Medicare MSA

The best consumer health plan in Medicare was quietly buried by the system that claims to protect patients.

In Chapter 9, we presented the Medicare Medical Savings Account (MSA) as the legislative and operational **blueprint** for a national system of age-based tax credits. The structure already exists: a fixed annual government contribution, high-deductible catastrophic coverage, and a personal savings account that rolls over unused funds tax-free. Patients have no network restrictions, no plan premium, and no bureaucratic interference. It is, by every measure, one of the **most patient-centered and portable insurance designs** in the entire Medicare program.

And yet — the Medicare MSA has barely registered on the national radar.

Enrollment remains minuscule. Most Medicare Advantage (MA) insurers don't offer it. The one carrier that briefly attempted nationwide rollout (Lasso) has now exited. Only Wisconsin offers an MSA today. So the question becomes: **why hasn't the Medicare MSA succeeded?**

The answer reveals a painful truth: while the law allows MSA plans to exist, the **payment structure, rating systems, and incentive architecture built by CMS and Congress quietly ensure their failure**. MSAs aren't rejected by consumers — they're avoided by insurers, because Washington designed the system to make them unprofitable.

For the patient, the Medicare MSA is a dream scenario:

- No monthly premium.
- Tax-free money from the government.
- Full catastrophic coverage after the deductible.
- Total provider freedom — **no network**.
- All unspent dollars roll over year after year.

This plan **should be the gold standard** for seniors who are healthy, travel, or want financial control. But they never get the chance. **Why?**

Because insurers won't sell what they can't profit from. The **system's rules were written to reward control, utilization, and third-party management**. The Medicare MSA offers **none of that** — and so it gets no support.

This is how good policy dies. From **legislation, regulatory neglect and structural bias**.

How Medicare Advantage Plans Are Paid (and the Role of Star Ratings)

To understand the challenges facing MSA plans, it's important to first grasp how Medicare pays private MA plans and what the **Star Rating** system does. **Medicare Advantage plans receive a fixed per-person payment from the federal government for each enrollee**. On average, this annual payment is roughly on the order of **$13,000–$14,000 per person per year** in recent years. This lump-sum payment (often called the "capitation" or "benchmark" payment) is intended to cover all of an enrollee's Part A and B health costs for the year. If the enrollee's costs exceed that amount, the plan, not Medicare, is on the hook for the difference; if the enrollee's costs are lower, the plan can profit – giving insurers an incentive to manage costs.

Star Ratings and Quality Bonus Payments: Medicare uses a **5-star quality rating system** to evaluate MA plan performance on various measures (customer service, preventative care, chronic condition management, member satisfaction, etc.). This isn't just a consumer information tool, since 2012 it has been directly tied to payments. **Plans that achieve 4 or more stars (out of 5) get a significant *quality bonus* added to their payments**. Specifically, a plan that earns a 4-star or 5-star overall rating qualifies for a **Quality Bonus Payment (QBP)**, which **increases its benchmark (capitation) rate by 5% (or 3.5% in some cases)**. In practical terms, a high-rated plan gets about a **5% higher payment from Medicare for each enrollee**, which can amount to hundreds of extra dollars per member to fund additional benefits or reduce premiums. In addition, the portion of savings that plans get to keep (the "rebate" if their bid is below Medicare's benchmark) is higher for good performers – for example, a 4.5-star plan retains 70% of the savings, while a 3-star plan only retains 50%. On the flip side, **plans rated below 4 stars get *no* bonus increase to their benchmarks** and have a lower rebate percentage, meaning **they receive substantially less revenue per enrollee** than their high-performing counterparts. The financial impact is huge: as one analysis noted, failing to reach 4 stars *"can cost plans hundreds of millions…even billions of dollars,"* since a 4→3 star drop eliminates the 3.5–5% payment boost and cuts rebate share from 65% down to 50%, affecting **every single enrollee's payment**.

Most MA plans today get bonuses – in 2025 about **75% of MA enrollees are in plans receiving a star bonus** – which underscores how integral the quality bonus has become to plan finances. *In total, Medicare will pay at least $12.7 billion in bonuses in 2025.* Plans often reinvest these bonus dollars into extra benefits (vision, dental, lower co-pays, etc.) to attract members, effectively leveraging the star system to compete in the market. In short, the Star Rating program has created a powerful incentive structure: **high quality scores translate into higher payments**, and those extra funds are used to offer richer benefits or premiums that further boost enrollment.

Medicare MSA Plans – How They Work and Their Appeal

A Medicare MSA plan is structured very differently from a typical HMO or PPO Medicare Advantage plan. **MSA plans pair a *high-deductible* MA insurance policy with a special medical savings account.** Here's how it works in outline:

- **Annual Deposit:** At the start of each year, Medicare **deposits a fixed amount of money into the MSA savings account** for the enrollee. This deposit comes out of the plan's Medicare funding. For example, if an MSA plan's annual deductible is $5,000, the plan deposits $2,000 into the account for the member (deposit amounts vary by plan). The enrollees can use this money to pay for **qualified medical expenses** during the year.
- **High-Deductible Coverage:** The MSA's insurance portion is a **Medicare Advantage plan that *only* kicks in after you meet a high annual deductible** (often several thousand dollars). Before you hit that deductible, **the plan pays nothing for Medicare-covered services** – you pay out-of-pocket, which is what the savings account is intended to help cover. *After* you reach the deductible, the MSA plan covers 100% of further Medicare-covered Part A and B costs for the remainder of the year (there are no co-pays once deductible is met, akin to catastrophic coverage).
- **No Provider Networks:** Uniquely, **MSA plans **cannot restrict enrollees to a provider network** or charge different in-network vs out-of-network cost-sharing. **You are free to use any doctor, hospital, or provider that accepts Medicare**, nationwide. This is a massive consumer advantage in theory – it's the kind of unfettered choice that no HMO (and not even PPOs, which still have networks) can offer in today's market. *The freedom to choose any Medicare provider* is a key selling point of MSAs.
- **No Part D drug coverage included:** By law, MSA plans **do not include prescription drug coverage**, so enrollees who want drug benefits must join a separate Part D plan. (MSA funds can be used to pay for medications and other qualified expenses, but those expenses don't count toward the medical deductible.)
- **No monthly premium:** MSA plans generally **have a $0 premium** for the medical coverage (since Medicare essentially gives the plan the bulk of funding directly as the deposit and coverage). Enrollees continue to pay their standard Medicare Part B premium to the government, but the MSA plan itself usually doesn't charge an additional premium. The trade-off is the high deductible but still less out of pocket maximum than most any other Medicare Plan.
- **Unused funds roll over:** Any money left in the savings account at year-end **rolls over** to the next year, remaining available for future healthcare needs. Importantly, though, if you leave the MSA plan, the money is yours to use for medical expenses (tax-free for qualified expenses), but you can't contribute new funds – only Medicare contributes to these accounts.

From a beneficiary's perspective, a Medicare MSA plan offers **low upfront cost (no premium), broad choice of providers, and protection from catastrophic costs** after the high deductible. It's essentially Medicare's version of a consumer-directed health plan. In *theory*, this model could appeal to healthier or more independent seniors, especially those accustomed to high-deductible plans with Health Savings Accounts (HSAs) in their pre-Medicare years. And indeed, analysts have noted that **MSAs could be financially advantageous for certain retirees** – e.g. those who don't anticipate high medical spending could come out ahead by pocketing unused account funds.

So why are MSA plans so scarce? Only a handful of insurers ever offered them, and enrollment is minimal. The answer lies in the *business side* – for insurance companies, MSA plans have proven extremely difficult to make viable under current Medicare rules. Two major policy-

related factors stand out: **(1) the inability of MSA plans to earn Star Ratings bonuses,** and **(2) the constraints of the 85% MLR requirement** given the MSA plan design. Together, these make the MSA model financially unattractive to insurers despite its consumer appeal. Let's examine each in depth.

Star Rating Bonus: MSA Plans Stuck Without the 5-Star Boost

One big handicap for MSA plans is how they fare in Medicare's Star Rating system. **In practice, all MSA contracts have been *unable to attain the 4-star threshold* needed for quality bonuses** – meaning MSA plans miss out on the ~5% payment bump that most competing MA plans receive. There are several reasons for this:

- **New and Small Contracts:** Every MSA plan is offered under its own distinct Medicare contract (with a unique contract ID, often an "H" number). Insurers can't "mix" an MSA plan into a larger contract that includes their other HMOs/PPOs for ratings purposes – it stands alone. This is problematic because new or small contracts **lack the multi-year performance data and member volume** that can help generate higher star scores. In fact, new MA contracts have no stars in their first year or two (they are not rated initially), and contracts with very low enrollment may not receive star ratings at all. Thus, an MSA plan starting up is essentially *guaranteed* to have no star bonus for its first few years. Even after that, with only a tiny enrollment, it's hard to statistically excel on all the measures.
- **Challenges Achieving Quality Metrics Without Networks:** By design, **MSA plans give enrollees total freedom of provider choice – but that very freedom makes it harder for the plan to influence or coordinate care in ways that drive quality metrics**. Traditional MA plans (HMOs/PPOs) use networks of doctors and hospitals, often employing care management programs, provider incentives, and care coordination to ensure members get preventive services, manage chronic conditions, and follow recommended care – all of which reflect in Star Rating measures (e.g. cancer screenings, diabetes control, hospital readmission rates). An MSA plan **has no contracted providers or care management leverage** – beneficiaries self-direct their care like in Original Medicare. As one expert observed, with MSA enrollees able to see any provider, **"the insurer does not have significant ability to influence physician practice patterns"**, and without strong provider integration, **"the quality metrics (which drive the Star rating) are difficult to achieve."** In short, the very feature that makes MSAs attractive – provider freedom – undercuts the plan's ability to proactively boost quality outcomes. The result tends to be average or below-average performance on measured indicators, keeping star scores low even though the consumers love them.
- **No Enhanced Benefits to Attract Higher Ratings:** Many high-star MA plans reinvest their bonus dollars into extra benefits or reduced cost-sharing, which can improve member satisfaction and outcomes (and thus star measures). MSA plans, stuck without a bonus, operate on tighter benefit budgets. They **cannot offer Part D drug coverage** (which indirectly affects some medication adherence measures), and by law MSAs also **cannot offer any supplemental benefits that cover the deductible** (no "first dollar"

coverage even for things like preventive care, which other plans often provide for free). These limitations mean MSAs have fewer levers to pull to try to raise quality or satisfaction metrics.

The cumulative effect is that MSA contracts will ever hit the 4-star mark. In fact, some MSA plans have had **"No Rating" or around 3 stars** in many years – which means **no quality bonus** and a significant revenue shortfall relative to other MA plans. *This is a crucial disadvantage.* **An insurer offering an MSA is forgoing the ~5% funding bonus that almost all its competitors receive.** As noted earlier, missing that bonus can equate to losing on the order of **several hundred dollars per member per year in payments**. For example, if the average MA capitation is ~$14,000/year, a 5% bonus is ~$700 extra per member. Equate that loss over one million members equals a $700 million dollar loss of revenue to the insurance company– these are funds that a non-bonus plan like an MSA simply won't ever qualify for that a 4-star plan does. Moreover, the MSA plan's rebate (the portion of unused benchmark it can use for benefits) is stuck at 50% instead of 65–70% for higher star plans, further squeezing the benefit dollars available. This translates into why would a company offer an MSA plan and lose out on hundreds of millions or even billions of dollars.

From the insurer's perspective, this is a huge deterrent. **Offering an MSA means knowingly operating at a ~5% revenue disadvantage per enrollee from the get-go**, *with no easy path to ever earning the bonus* due to the structural reasons above. As one actuary put it, *"Without a high Star rating, the insurer's ability to offer a competitive product is increasingly difficult due to lower available revenue."* In plainer terms: an MSA plan will bring in less money from Medicare than a typical plan, but still has to meet the same consumer expectations. This makes it hard to compete on premiums or extras, since the plan has fewer dollars to work with.

It's worth noting that Congress did not necessarily intend to penalize MSAs – the quality bonus program was created in the Affordable Care Act to reward quality broadly. However, a side effect has been **MSA plans get left out of the bonus system**, another horrible effect of the ill-conceived ACA and thus left behind in the MA "arms race" of richer benefits. Policymakers looking at this issue have floated ideas like adjusting the star methodology for MSAs or otherwise allowing them to qualify for incentive payments, given their different model. So far, though, no special accommodation exists: *MSAs must play by the same star rules, and almost always lose that game.* This star bonus gap is a key reason few insurers venture into the MSA market.

The 85% Medical Loss Ratio Rule: A Misfit for High-Deductible MSAs

The **second major barrier** is the **Medical Loss Ratio (MLR) requirement** imposed on Medicare Advantage plans by the ACA. **MA plans must spend at least 85% of their revenue on medical care and quality improvement, leaving no more than 15% for administration and margin**. If a plan's MLR falls below 85% in a given year, the plan **must rebate the difference back to CMS** – effectively returning excess profits – and after multiple years of

missing MLR, the plan can face sanctions or even termination. The intent of this rule is to ensure plans devote most of their funding to patient care rather than profit.

While this sounds straightforward, **the MLR formula interacts very awkwardly with the MSA design.** Under MLR accounting, the **"medical expenses"** for an MA plan include costs like paid claims for Part A and B services, certain quality improvement activities, and also **any money deposited into MSA accounts**. The "revenue" includes the total capitation payments from Medicare (including that deposit amount). At first glance, one might think an MSA plan would meet the 85% MLR by counting the deposit as an expense – but the reality is more complex:

- **Low Claims Cost by Design:** MSA plans have a high deductible (often many thousands of dollars). **In a given year, a significant share of enrollees may *never even hit the deductible*, meaning the plan pays $0 in actual claims for their medical services**. The plan's "medical spend" for those members is essentially just the deposit it put in their account. Suppose a plan's annual capitation per member is $10,000, and it deposits $2,000 to the MSA. If the member uses only $1,000 of the account on care and never triggers insurance coverage, the plan's incurred claims = $0 (insurance never paid anything beyond the deposit). Can the plan count the full $2,000 deposit as a "medical expense" in the MLR? **Yes, regulations allow counting the MSA deposit in the MLR numerator**, since it's funding medical spending. But even including that, the **MLR might be very low**. In this example, numerator ~$2,000 (deposit) on denominator ~$10,000 (revenue) – an MLR of only 20%. That flunks the 85% test by a wide margin.
- **Structural Difficulty Meeting 85%:** In order for an MSA plan to achieve an 85% MLR, the combined total of **deposit + claims paid after deductible + quality expenses** must equal 85% of the plan's revenue. But typically, the **deposit is much smaller than the total revenue** (because the difference is intended to cover any catastrophic claims and the insurer's costs/profit). If few enrollees have claims exceeding the deductible in a year, the plan's paid claims might be near zero for most members. In essence, the plan ends up *not spending enough* of the Medicare dollars on medical costs in that year, even though that just reflects healthy members. This is a peculiar situation: the plan "saved" money by enrollees not needing care, yet the rules treat that as a problem, requiring rebates.
- **Rebate and Profitability Impact:** The 85% MLR rule has teeth. If an MA contract's MLR comes in below 85%, the **plan must refund the difference to CMS**. For instance, an MLR of 70% means the plan has to pay back 15% of its revenue. This effectively claws back any profit. An MSA plan with an inherently low claims payout could easily face this scenario. In fact, early experience with MSA plans showed that maintaining compliance with MLR was a significant challenge – the plans had to either increase benefits (or deposits) or risk paying rebates. In the long run, if a plan fails MLR for 3 consecutive years, CMS can suspend enrollment; 5 consecutive years triggers termination of the contract. No insurer wants to be in that position.

In summary, **the MSA's high-deductible structure tends to produce lower medical payout ratios than the 85% threshold, especially in years with healthier enrollees.** The plan might *appear* to be "over-collecting" relative to what it spends on care – not because it's gouging, but because by design it is providing catastrophic coverage and many members didn't need costly

care that year. Yet the law doesn't bend for that nuance: 85% is 85%. An insurer can't realistically jack up the deposit enough to meet MLR without erasing any margins, since the deposit itself comes out of the same funding pool. In effect, the **MLR rule forces MSA plan sponsors to operate at a loss or very thin margins unless utilization is high**. This is an obvious disincentive for companies. (Notably, the MLR rule was implemented in 2014, years after MSAs were created – it's another example of a well-intentioned policy that unintentionally undercuts the consumer-directed model.)

Between the star bonus disparity and the MLR pressure, it becomes clear why **"it doesn't make sense for companies to offer the [MSA] product at scale"** under current conditions (as the question aptly put it). An insurer offering an MSA is effectively *penalized twice* – first by receiving lower revenue (no bonus), and second by possibly having to refund revenue if it doesn't spend enough of it (MLR rebate). Any one of these alone would make the product less attractive to offer; together, they have nearly extinguished MSAs. Indeed, industry observers have described the Medicare MSA as *"an idea whose time never came"*, noting that it "struggled to attract plan sponsors and users" and now is "almost gone" from the market.

Why Fixing This Could Be a Bipartisan Opportunity

It's worth highlighting that **the concept of Medicare MSAs initially had broad political appeal**. The MSA option was first introduced as a demonstration in the late 1990s (Balanced Budget Act of 1997) and then made a permanent part of Medicare in 2003 by the Medicare Modernization Act. The idea was to give beneficiaries more control over healthcare dollars – an approach traditionally favored by fiscal conservatives – while still protecting them from catastrophic costs (an idea also appealing to consumer advocates). In many ways it was a *bipartisan* compromise: combine personal savings incentives with the safety of Medicare coverage.

However, the subsequent layering of the star bonus system and MLR requirements (enacted in 2010 ACA) inadvertently stacked the deck against MSAs. Congress likely did not foresee these interactions – star bonuses were aimed at quality improvement, and MLR at value for money, but neither was tailored with MSAs in mind. Now that we have over a decade of experience, it's evident that these rules have had the side effect of **stifling an innovative plan type** that could otherwise appeal to a segment of seniors. **Recognizing this could pave the way for a bipartisan policy fix.**

Both political parties have reasons to support making MSAs more viable:

- **For proponents of free-market solutions and choice:** The MSA is the ultimate choice-based Medicare plan – enrollees direct their own care and spending. Enhancing MSAs aligns with conservative and libertarian ideals of consumer-directed healthcare (similar to HSAs, which have broad GOP support). Removing unfair hurdles (like adjusting the star bonus or MLR rules) would allow the market to decide if MSAs can compete, rather than regulators picking winners.
- **For proponents of cost-saving and innovation:** If structured well, MSA plans could potentially save Medicare money by encouraging cost-conscious consumer behavior.

They also fill a niche for beneficiaries who prefer flexibility over extras. Lawmakers on both sides have shown interest in **alternative payment models** that might reduce costs long-term. A functioning MSA option could be one such model. *Notably, there is nothing inherently partisan about MSAs* – they were part of a bipartisan law in 2003. Adjusting the regulations to give MSAs a fair shot could attract support from moderates in both parties who favor more choices for Medicare beneficiaries.

- **Recent legislative interest:** While not heavily publicized, there have been discussions in Congress about **modernizing the MA quality bonus program** and revisiting aspects of MA regulation. If reform is on the table, inserting a provision to, say, **exempt MSA plans from certain star rating criteria or allow a different bonus structure** could be a relatively small tweak with bipartisan appeal. Similarly, an adjustment to the MLR calculation for MSAs (for example, treating unspent deposit funds as "spent" on beneficiaries for MLR purposes, or lowering the threshold for MSA plans) could relieve the pressure without undermining the overall intent of MLR.

In short, **Congress has shown before that it can come together to improve Medicare Advantage** – the initial creation of MA (Medicare Choice), the introduction of star bonuses, etc., all passed with bipartisan input. A targeted fix to *revive the MSA option* could likewise gain cross-party support if framed correctly. It speaks to empowering patients (typically a Republican theme) *and* improving Medicare's benefit design choices (which Democrats have also supported when it helps consumers).

The Blueprint for Revitalizing MSAs

To wrap up, what would a blueprint for expanding MSA adoption look like? Based on our analysis, the key elements would be:

- **Level the Quality Bonus Playing Field:** Ensure MSA plans are not permanently shut out of quality incentive payments. This could involve creating an **alternative quality assessment mechanism for MSAs** or allowing an interim star rating for new/small plans so they aren't at a 5% payment deficit by default. Another idea is to **decouple the bonus from network-dependent metrics** for MSAs – recognizing that lack of care management is a feature, not a flaw, of the model. If MSA plans could earn bonuses (or a equivalent funding bump) for providing good value or member satisfaction in other ways, insurers would be more willing to offer them.
- **Adjust the MLR Requirement for MSAs:** Policymakers could **exclude MSA plan contracts from the strict 85% rule or modify how the MLR is calculated** for them. For example, if funds deposited in enrollees' accounts (which ultimately belong to the enrollee) were treated as fully "spent" on patient care even if not used within the plan year, the MLR would be higher. Or regulators could set a slightly lower MLR threshold for MSAs recognizing their unique payout structure, so that plans aren't forced to refund money simply because their enrollees stayed healthy.
- **Preserve Consumer Protections While Encouraging Entry:** The blueprint should still ensure MSA enrollees receive good value – for instance, requiring transparency about how the plan works and monitoring outcomes – but remove unnecessary barriers. *One idea:* a **pilot program or temporary waiver** that encourages insurers to offer MSAs in

more regions, with protections against punitive star/MLR consequences for a few years while data is gathered. This would allow the model to prove itself at scale.

- **Leverage Bipartisan Support for HSAs/FSAs:** Members of Congress have repeatedly supported tax-advantaged health accounts (like expanding HSAs, or introducing new savings vehicles). Tapping into that sentiment, advocates can pitch Medicare MSAs as the logical extension for seniors – essentially "Medicare HSAs." Emphasizing stories of beneficiaries who want that choice could humanize the issue.

Ultimately, the **Medicare MSA plan represents a bold idea – letting seniors manage some of their healthcare dollars directly and giving them total freedom of provider choice, backed by catastrophic coverage.** It's an almost *universal* truth in insurance that you rarely get to see any provider with no referral and no network; the MSA is one of those unicorns. The lack of network alone would make it attractive to many consumers *if* the product were made more widely available and financially sustainable for insurers to offer.

In conclusion, the current Medicare Advantage landscape has unintentionally sidelined MSA plans through the star rating bonus structure and the MLR requirements. We have thoroughly researched and validated the statements: insurers on average receive about **$14,000 per MA enrollee annually from Medicare**, but **if a plan doesn't hit the 4-star mark, it forfeits a bonus worth roughly 5% of that** (hundreds of dollars) and loses out on enhanced rebate funds. **MSA plans, by their nature, have struggled to ever qualify for these bonuses**, putting them at a permanent revenue disadvantage. Additionally, **not meeting the 85% MLR can force an MSA plan to rebate money** – a likely scenario given low claims – which further **erodes the business case for MSAs**. These factors explain why companies haven't offered MSAs at scale despite the consumer appeal of network-free coverage.

The *blueprint* for revitalizing MSAs would involve policy changes to remove or lessen these disadvantages – something that is achievable through congressional action or CMS rule adjustments. There is historical precedent and potential bipartisan interest in doing so, once policymakers understand how the MSA has been unintentionally hobbled. Fixing these issues could unleash a new, *truly flexible* option in Medicare that empowers beneficiaries and injects more competition into Medicare Advantage. Given the partisan divides on many health care issues, **this is one area where a bipartisan win could be possible** – restoring the Medicare MSA to the prominent, innovative role it was originally envisioned to play.

Key Takeaway

The Medicare MSA never scaled because it was designed inside a system that rewards higher spending. Age-Based Tax Credits can avoid this trap by aligning incentives, ensuring universal awareness, and making the credit the default option for anyone outside ESI—so that the market can't bury it out of sight.

Chapter 11: Empowering Patients – The Wealth-Building Power of HSAs

How Age-Based Tax Credits Turn Healthcare Waste into Personal Wealth

The problem with American healthcare isn't just the cost. It's that the money doesn't go to the people it's supposed to benefit. Every year, trillions of dollars flow through the system — but instead of empowering patients, that money vanishes into employer-sponsored insurance (ESI) premiums, bloated hospital charges, and insurance company administration. Nothing gets saved. Nothing gets owned. And nothing builds wealth.

This chapter explains how **age-based tax credits**, when paired with **Health Savings Accounts (HSAs)**, solve this problem permanently. We're not just reforming healthcare. We're flipping the model: from wage suppression and premium waste to individual ownership, lifetime savings, and real economic mobility.

Under our model, Americans are no longer trapped in a system where insurance is rented through an employer, premiums disappear annually, and the true cost is hidden from view. Instead, individuals receive fixed, age-based credit. If they choose an affordable plan, **the unused credit is theirs — rolled into a personal HSA**. That money grows, tax-free, every year. Eventually, it funds not just healthcare — it builds generational wealth.

This is the foundation for a voluntary revolution: a system that ends job lock, shrinks the ESI monopoly, and puts financial control back where it belongs — with the patient.

Section 1: The Financial Failure of ESI

Employer-sponsored insurance (ESI) is the silent thief in America's economy. It consumes over **$2.5 trillion** per year in premiums — costs that **come directly out of employee wages**, even when workers are told "the company pays."

It's a lie. And worse, it's a trap.

- A typical Nebraska family plan now costs over **$40,000 per year**. That's more than a mortgage.
- The government subsidizes these plans by exempting premiums from taxes — a hidden tax break worth over **$300 billion annually**.
- Employers finance their cost to employees by holding down wages, capping raises, and gutting retirement contributions.
- And employees never see the money — it goes straight to insurance companies, whether they use the plan or not.

This system doesn't build anything. It doesn't store value. It doesn't prepare for the future. It is **purely consumptive** — and that's exactly how insurers like it.

Now compare that to what happens when we The **ESI monopoly fades away as age-based tax credits take hold**.

Section 2: Age-Based Credits The flow of Money and the Worker

Under our model, every American receives a **fixed annual credit** to purchase health insurance, based solely on age. It's portable. It's simple. And it's **owned by the individual**, not the employer.

Here's the difference:

- In the ESI system, $40,000 is spent on a family plan. The employee never sees it.
- Under age-based tax credits, the same household might receive 18,000 in annual credits. If they choose a lean, high-deductible plan that costs $10,000, **the remaining $8,000 goes into their HSA.**

That money **stays with the family**. It rolls over year after year. It grows. It becomes a long-term asset.

Multiply that by millions of households and hundreds of billions in reallocated premiums, and you get the biggest shift in wealth ownership in modern health policy history.

This is what employer-based insurance has been stealing from the American worker for 70 years the **right to keep what they don't spend.** Age-based credits fix that.

Section 3: The Employer Shift — From Premium Payer to Wealth Partner

Critics might ask: "Won't employers just stop contributing altogether?" But history — and incentives — suggest otherwise.

Today, employers offer health insurance because they're locked into the ESI model. Once that model begins to fade, they'll pivot — not abandon support but **shift it to what employees actually value: portable dollars they control.**

Already, some companies offer **HSA contributions as a recruitment tool**. That trend will explode as age-based credits gain traction. Once employers are **no longer burdened with the full cost of insurance prmiums**, they will:

- Redirect a portion of savings into **tax-deductible HSA deposits**.

- Allow employees to **choose their own coverage** on the open market.
- Use HSA matching or lump-sum contributions as a **benefit employees can keep**, not lose when they quit or change jobs or become to sick to work. Personal, Portable, Affordable health insurance at a fraction of the cost.

And unlike ESI premiums — which reset to zero each January **HSA dollars accumulate.** The same dollars that used to be lost forever in group premiums now **belong to the employee for life along with any investing gains that dollar earns.**

This is how the shift from ESI to age-based credits becomes a **wealth-building engine.** Employers still contribute — but now, they contribute to **ownership and savings** instead of consumption.

Section 4: From Expense to Asset — The Math of Lifetime HSA Growth

Let's walk through a real-world example.

Suppose a 25-year-old receives a $3,000 age-based credit. She selects a catastrophic plan that costs $2,000, leaving $1,000 to be deposited into her HSA.

She repeats that every year. If she invests that $1,000 annually with modest returns (say, 5–6%), by age 65 she'll have accumulated between **$180,000 and $225,000** — **tax-free**, fully liquid for qualified medical expenses.

Add modest employer contributions at a fraction of what is spent on health insurance over the years and that number can easily exceed **$300,000-$1,000,000** by retirement.

Now imagine a two-income household doing this for 30+ years. **We're talking about $500,000–$$2,000,000 in combined HSA balances**, conservatively. For most families, that's more than their 401(k). And unlike a 401(k), **HSA withdrawals for healthcare are tax-free — every dollar is worth a dollar.**

This isn't theory. It's already legal. The only reason more people don't do it is because **ESI steals the opportunity before they get the chance.**

Section 5: The Best of Both Worlds — Coverage and Compounding

Our age-based credit model doesn't force people into high deductibles. It gives them the **choice**.

But for those who are healthy, younger, or prefer to self-insure part of their risk, it opens the door to **massive financial upside**.

- In ESI, if you don't get sick, you lose.
- In age-based credits + HSAs, if you don't get sick, you win — because you **keep the surplus**.

That surplus isn't some empty rebate or gimmick benefit. It's real money in a real account, **earning real returns**, owned by the family, used when needed — or saved for when it matters most: long-term care, chronic illness, retirement health costs.

And when the time comes, HSA funds don't vanish. They roll to a spouse. They cover Medicare premiums. They **protect families from out-of-pocket devastation.** And they don't disappear when the employer goes out of business, downsizes, or restructures.

This is **insurance plus investment.** It's **security plus ownership.** It's what the current system was never designed to deliver — and what the new system makes possible for everyone.

Section 6: Generational Wealth — From Healthcare Waste to Inheritance

In the current model, your health dollars vanish every year. You can't save them. You can't invest them. You can't pass them on.

In our model, **you can do all three.**

HSA balances **belong to the individual**. They are not "company money." If unspent, they grow. If untouched, they roll to a spouse. If preserved, they become part of the estate. And while non-spouse heirs do pay tax on inherited HSAs, the money is **still theirs — and still available to cover final expenses or settle bills**.

Over a lifetime, families can accumulate **hundreds of thousands of dollars and even millions in HSA assets**, which:

- Reduce out-of-pocket burden during retirement.
- Create flexibility to delay Social Security or bridge to Medicare.
- Protect widows and caregivers from medical bankruptcy.
- Supplement other retirement savings.

And perhaps most importantly, **they change the narrative**. Healthcare spending is no longer a drain. It's a driver of **family security.**

Wealthy families already do this — they structure savings to grow tax-free and pass down assets. **Now every American can do the same.** All it takes is eroding the ESI monopoly and letting people keep what they earn.

Conclusion: From Hidden Premiums to Open Prosperity

ESI was sold to America as a benefit. It wasn't. It was a wage diversion — a way to hide costs, inflate insurer profits, and lock workers into a system where they never build equity.

Age-based tax credits + HSAs reverse all of it.

- They unlock trapped compensation.
- They redirect spending from premiums to savings.
- They turn temporary benefits into **permanent assets**.
- And they build intergenerational wealth for the middle class — not just the elite.

This chapter isn't just about fixing health care. It's about **empowering people to own the money already being spent in their name.**

The savings are there. The dollars are already flowing. We're just moving them from insurance companies to individual accounts — where they belong.

This is what healthcare reform should look like: **fewer handouts to carriers, and more compound interest for families.** It's the best of both worlds — security when you need it, savings when you don't.

And it all starts by offering a voluntary solution to shut off the siphon of employer-sponsored insurance and giving Americans their own stake — not just in health care, but in their financial future.

Key Takeaway

Implementing Age-Based Tax Credits doesn't require a revolution, it just requires redirecting existing subsidy dollars directly to individuals and letting them decide how to spend them. With a voluntary, phased rollout, ABTCs can dismantle the employer-sponsored insurance system, lower national healthcare costs, and build personal healthcare wealth—without the political bloodbath of forced change.

Chapter 12: Voluntary Revolution – How the System Unwinds on Its Own

Why Age-Based Tax Credits Will Replace Employer Insurance Without a Single Mandate

Every major healthcare reform in U.S. history has relied on **mandates, penalties, or subsidies** to force people into a new system. Whether it was the employer mandate of the Affordable Care Act (ACA), the individual mandate that followed, or the Medicaid expansions that tied coverage to income, the message has always been the same: **change requires coercion**.

But what if it doesn't?

What if the current system is so unsustainable — so economically backward, inefficient, and burdensome — that all we have to do is **give people the option to leave**, and the entire structure collapses by choice?

That's exactly what age-based tax credits will do. They don't ban employer-sponsored insurance. They don't require people to leave it. They simply **offer a better deal** — a portable, personalized credit that grows with you and funds your own insurance and savings account.

And that alone is enough to trigger a **voluntary revolution** — one that starts slow, then accelerates, until the old system becomes obsolete.

Section 1: Why ESI Collapses Without a Fight

Employer-sponsored insurance (ESI) is not held in place by loyalty. It's held in place by **default and inertia**.

- Most workers don't "choose" their coverage — they rent whatever their employer offers.
- If the employer stopped offering insurance, most employees wouldn't fight to keep it. They'd shop, compare, and find what works for them.
- Younger, healthier workers in particular get a raw deal under ESI — they pay the same or more than older workers but use far less care.

When you give people **a flat, age-based credit** — say $3,000 for a 30-year-old — and let them shop outside the employer plan, something interesting happens: **they leave**.

They realize:

- They're losing thousands in take-home pay to support an overpriced group plan.
- They could get similar or better coverage elsewhere at a fraction of the cost — and keep the difference in a Health Savings Account (HSA).

- Their coverage could follow them from job to job, across states, or into self-employment. They have individual ownership and portability. What a concept!

This doesn't require political persuasion or top-down enforcement. It just requires **clarity and math**. Once the first wave of people leave, ESI begins to unravel — not because anyone banned it, but because no one wants it anymore.

Section 2: The Tipping Point Effect

The exit from ESI won't happen all at once. It will happen **gradually — then suddenly**.

- **Phase 1**: Younger, healthier workers opt out. They find they can buy high-deductible plans for less than the value of their credit and bank the rest. They now have coverage and a growing HSA.
- **Phase 2**: Employers take notice. They realize the healthiest employees — the ones who subsidize the group plan — are disappearing. This drives up premiums for those who remain.
- **Phase 3**: Employers stop offering insurance altogether. They replace it with cash raises, defined HSA contributions, or stipends. Workers prefer it. Recruitment improves.
- **Phase 4**: Insurers follow the money. They start designing plans for individuals again — portable, high-value, HSA-compatible, with real innovation. The individual market reawakens.

At each stage, **the old system becomes harder to justify and harder to sustain**. It doesn't get banned. It just fades. Voluntarily.

We've seen this before — in retirement savings. As 401(k)s replaced pensions, no one needed to outlaw pensions. People simply preferred flexibility, ownership, and control.

Healthcare will follow the same path — **once we offer the option**.

Section 3: Why No One Misses the Old System

When people walk away from ESI, they don't look back. Why?

Because what they're leaving wasn't actually working for them. It was:

- Tied to their job.
- Hidden in their wages.
- Unavailable during unemployment or job transitions.
- Designed around maximizing claims, not protecting wealth.

What they're gaining is:

- A clear, predictable benefit.
- An account that grows when they spend less.
- Coverage they can keep, no matter their employer.
- A plan they choose, not one chosen for them.

This is not theoretical. When individuals experience the HSA-based model — as they already do in Medicare MSAs or high-deductible plans — **they quickly realize how much power they've been giving away.**

The only reason more people haven't left is because **they haven't been given a way out**. Age-based tax credits provide that exit — and once it exists, the traffic is one way.

Section 4: What Happens to Medicaid and the ACA

Critics often ask, "What about low-income individuals?" or "Won't this hurt Medicaid expansion?"

The answer is simple: **this model replaces them, voluntarily, over time**.

- Not everyone on Medicaid is sick or poor. Many are young, healthy adults or working families.
- Age-based tax credits provide **guaranteed access to funds** for anyone, regardless of income.
- For many people currently on Medicaid or ACA plans, the credits will allow them to buy better coverage — without state red tape or federal claw backs.

This isn't about gutting public programs. It's about offering **a parallel path** that people can opt into when it's better for them.

Over time:

- **Medicaid enrollment shrinks** — not by cuts, but by disinterest.
- **ACA subsidies disappear** — because people choose the simpler credit instead.
- **Federal and state spending drops** — because fixed credits are more efficient and predictable than open-ended entitlements.

In short, **the safety net doesn't go away — it becomes smaller, smarter, and optional.**

Section 5: Employers Will Lead the Exit

ESI is as much a burden on employers as it is on workers. Businesses are tired of:

- Managing plan documents, networks, and compliance headaches.
- Watching premiums rise 5–10% every year.
- Absorbing health risk unrelated to business productivity.

When given the opportunity, employers will do what's in their best interest: **get out of the insurance business** and give workers the money instead.

They'll:

- Offer HSA contributions instead of group plans.
- Increase wages, knowing workers now have guaranteed credits.
- Let employees choose their own insurance, on their own terms.

This isn't theoretical. It already happens in small business environments and self-employed households.

Age-based credits **make it scalable**. They give employers a simple exit ramp. And once a small percent of employers adopt the model, the rest will follow — not because they're forced to, but because they have to stay competitive.

Section 6: No Legislation Needed to Force the Transition

One of the most powerful aspects of this proposal is that it doesn't require 2,000 pages of legislation, a new federal agency, or a mandate.

The transition to age-based tax credits and individual ownership happens **organically**:

- As people realize they can spend less and keep the difference.
- As employers realize they can raise pay and cut compliance costs.
- As insurers realize there's a growing market of engaged, cost-aware buyers.

All the government has to do is:

1. Authorize the credits.
2. Allow people to opt out of ESI and ACA plans.
3. Let competition do the rest.

Once the incentives are realigned — once the money belongs to the individual — **the market unwinds the old model on its own.**

Conclusion: The System Collapses Without a Fight

This is not a forced revolution. It's a voluntary exodus.

ESI isn't defended because people love it. It's defended because people don't realize they have a choice.

Once that choice exists — once Americans see that age-based tax credits let them **own their coverage, keep their savings, and control their future** — the system unravels from within.

No protests. No mandates. Just freedom.

A revolution not of resistance — but of recognition.
Of a better way.
And once people start walking that path, **no one goes back**.

Key Takeaway

A voluntary revolution is the only realistic path to dismantling the $2 trillion annual waste of employer-sponsored insurance and bloated subsidies. Age-Based Tax Credits create that revolution—not by force, but by aligning financial incentives so strongly that people choose the better option on their own. Over time, this quiet shift will reshape American healthcare, lower costs for everyone, and give individuals—not employers or Washington—ownership of their health future.

Chapter 13: A Healthcare Revolution – Envisioning the Reformed Future

How Ending the Employer Insurance Monopoly Transforms America

This book began with a question: **What if the greatest financial scam in modern American life isn't a Ponzi scheme or a Wall Street crash — but the very way we finance health Care?**

What followed was a journey through decades of distortion — how employer-sponsored insurance (ESI) emerged by accident, how it devoured wages, inflated costs, rigged incentives, enriched insurers, and locked Americans into a job-linked system they never chose.

We exposed the bipartisan cowardice that preserved it, the subsidies that bloated it, and the false sense of security that sustained it. Then we introduced a solution: **age-based tax credits paired with Health Savings Accounts (HSAs)** — a simple, portable, voluntary system that lets individuals control their own healthcare dollars and build wealth over time.

In this final chapter, we look forward. Not with fear — but with clarity and conviction.

Because once the ESI system unwinds, what rises in its place isn't chaos.

It's **liberation**.

Section 1: Wages Rise, Costs Fall

In the new system, employers no longer funnel tens of thousands of dollars per employee into hidden premiums. That money — formerly lost to insurer profits and inflated group plans — now shows up where it belongs:

- **In higher take-home pay**.
- **In direct HSA contributions**.
- **In true total compensation, visible and earned.**

For decades, Americans were told that slow wage growth was a mystery. It wasn't. It was ESI. And now that burden is gone.

Meanwhile, premiums fall. Why?

Because individuals shop for value. They reject overpriced plans. They reward insurers who innovate and punish those who pad networks and charge more.

In a competitive market where every dollar matters — and the unspent dollars roll into personal savings — **inflation ends, and value returns**.

Section 2: Portability, Freedom, and Ownership

Under age-based credits, health coverage follows the person — not the job.

- You can switch employers without changing plans.
- You can move states without starting over.
- You can quit, retire, freelance, or start a business — and your coverage stays with you.

No more COBRA. No more panic at layoff. No more gaps or requalifying periods.

What's more, your savings stay with you. The HSA you build isn't a company perk. It's your money — for now, and for the future. It covers vision, dental, long-term care, or any qualified expense. And if you stay healthy, it keeps growing.

You own it all.

Section 3: A Shrinking Insurance Industry (and Why That's a Good Thing)

In the current system, insurance companies sit between you and your doctor — and take a slice of every dollar.

In the reformed system, their power fades.

- They offer catastrophic coverage — real insurance — not micromanaged plans.
- They compete on price and performance — not network gimmicks or mandate compliance.
- Their profits shrink — because the patient is now the payer, and the payer chooses differently.

Insurers still have a role — but no longer as **gatekeepers, middlemen, or campaign donors**. Their grip on American wallets ends when Americans own their healthcare dollars.

Section 4: Government Programs Begin to Fade

When age-based credits become the norm, people opt out of:

- **Medicaid** — because they can afford private coverage on their own.

- **ACA subsidies** — because the flat credit is simpler and doesn't punish work.
- **Employer plans** — because they're no longer needed or wanted.

And with every opt-out, **taxpayer burden drops**.

The federal government no longer sends blank checks to insurers through tax exclusions, subsidies, or expansion programs. It sends one defined credit per person, per year. Predictable. Containable. Transparent.

The safety net remains for the most vulnerable — but the **default becomes independence, not dependence.**

That's not just policy. That's **economic justice**.

Section 5: A New Culture of Personal Empowerment

In the old system, healthcare felt confusing, fragile, and dehumanizing.

In the new system:

- People understand what they're paying for.
- They have incentive to stay healthy, shop wisely, and save more.
- Families make informed decisions — not out of fear, but confidence.

This mindset shift changes everything. When people have **skin in the game, savings on the line, and security in their hands**, they become more proactive, more resilient, and more invested in their own well-being.

Health doesn't just become a cost — it becomes **a legacy to build and protect**.

Section 6: Political Power Shifts Back to the People

ESI isn't just an economic distortion — it's a political one.

- It props up insurance companies who lobby against reform.
- It feeds a campaign finance loop where politicians protect the system that pays for their reelections.
- It ensures dependency — so workers are afraid to leave jobs, protest, or demand better.

When age-based credits replace ESI, that cycle ends.

- Insurers lose their guaranteed revenue stream.

- Politicians lose their incentive to coddle insurers.
- People lose nothing — and gain freedom.

This is how healthcare becomes a tool of democracy again. Not a source of corruption — but a symbol of control restored to the citizen.

Conclusion: We Don’t Need Permission to Fix It

The revolution this book describes doesn’t require waiting for Congress to find courage.

It begins the moment we acknowledge the truth:

- That ESI is not a benefit.
- That healthcare inflation is engineered.
- That both parties preserved a system designed to serve insurers, not individuals.

And it accelerates the moment we choose something better:

- A portable, age-based credit that replaces distortion with clarity.
- A personal HSA that rewards thrift and builds wealth.
- A voluntary opt-out that shrinks the old system with every person who walks away.

This is the **great unwinding** of the Great American Health Care Scam. Not by mandate. Not by protest. But by **exit**.

One person at a time. One credit at a time. One savings account at a time.

Until what was once the greatest scam… becomes the greatest return to freedom, ownership, and prosperity in American healthcare history.

Chapter 14: Wall of Shame – How Politicians from Both Parties Cemented the Scam

Every financial scam requires three ingredients: a hidden cost, a false promise, and a trusted messenger. In the case of the American health care system, those messengers wore flags on their lapels and campaigned on promises to make things better — while quietly reinforcing the system that made everything worse.

This chapter isn't about party politics. It's about accountability. Because no matter who you voted for, chances are your leaders helped rig the employer-sponsored insurance (ESI) system deeper into place — and made sure that the trillions in waste, inflation, and lost wages continued to benefit insurers, not individuals.

Rick Scott: From Fraud to Favoritism

Before Rick Scott was a U.S. Senator, he was CEO of Columbia/HCA — a hospital chain fined $1.7 billion for the largest Medicare fraud in U.S. history. Under Scott's leadership, the company falsified cost reports, engaged in illegal kickbacks, and upcoded diagnoses. Whistleblowers testified he pressured his CFO to hide $100 million a year in tax liabilities, costs ultimately shifted to employers and employees through higher premiums. As Florida Governor, Scott approved Blue Cross Blue Shield's conversion to a for-profit entity, allowing $1.8 billion in tax-exempt reserves to disappear into executive-controlled foundations, waiving retroactive taxes, and granting no compensation to policyholders. Premiums spiked 17.6% the following year, and BCBS executives donated $785,000 to his campaign.

Barack Obama: The Grand Betrayal of Reform

Obama promised Americans they could keep their plans, would see premiums drop by $2,500 a year, and that the ACA would reduce administrative waste. In reality, ESI enrollment rose from 156 million to 159 million, average family premiums jumped 82% ($13,375 → $24,327), and 4.7 million plans were canceled. Administrative costs ballooned with 17,000+ new regulations, $134 billion in failed IT projects, and U.S. admin spending growing to eight times Canada's per capita. The ACA entrenched ESI via employer mandates, repealed the only meaningful cost-control tool (Cadillac Tax), and expanded insurer profits from $15B to $43B annually.

Marco Rubio: The $43.5M Florida Exchange Scam

As Florida House Speaker, Rubio created the Florida Health Choices Corporation (FHCC), pitched as a market-driven ACA alternative. Between 2011–2019 it received $43.5 million in

federal grants yet sold zero health plans, only 47 dental plans, and racked up $7.3 million in administrative costs. Rubio also led the GOP effort to kill ACA risk corridor payments, collapsing 16 of 23 co-ops and spiking Florida premiums 83% by 2017. He blocked Medicaid expansion, rejected $66 billion in federal funds, and pushed legislation to make ESI tax breaks permanent — cementing employer coverage while the individual market withered.

Nancy Pelosi: The $280B ACA Bait-and-Switch

Pelosi promised lower costs and fairer treatment for every patient. Instead, average family premiums rose 82%, deductibles jumped 155%, and 42 million remain uninsured. She killed the public option after insurer lobbying, imposed an employer mandate without cost controls, repealed the Cadillac Tax, allowed massive hospital consolidation, and oversaw $134 billion in IT failures with HealthCare.gov and state exchanges. Family financial gains from healthcare ties — including $5.2M from industry connections — compounded the perception of conflict of interest.

Joni Ernst: From Repeal Rhetoric to ACA Expansion Advocate

Elected on a promise to repeal the ACA, Ernst voted for symbolic repeals without a replacement plan. She has since supported extending expanded ACA premium tax credits — a temporary COVID measure — without structural reform, reinforcing the ESI/ACA framework and ensuring ongoing subsidies to insurers.

Rand Paul: The Purist Who Preserved the Scam

Paul opposed the 2017 American Health Care Act — the only viable ACA replacement to include age-based tax credits — calling it "Obamacare Lite." His refusal, along with a small bloc of Senators, killed the bill and preserved the ACA’s ESI-entrenching mandates, blocking any path toward portable, individually-owned coverage.

Chuck Schumer: Celebrating Dependency as Success

Schumer hails ACA Medicaid expansion as proof of success, despite adding over 22 million to a welfare program with limited provider access. He resists reforms to the employer tax exclusion or adoption of age-based credits, leaving 159 million tied to ESI and costs spiraling.

Ted Cruz: The Firebrand Without a Plan

Cruz vowed to repeal every word of Obamacare but offered no workable replacement. He rejected age-based credits, preserved ESI tax advantages, and contributed to the failure of the 2017 reform effort — effectively maintaining ACA's framework.

Ron DeSantis: The Freedom Caucus Blockade

As a Freedom Caucus member, DeSantis opposed the 2017 ACA replacement with age-based credits and enhanced HSAs, dismissing HSAs as having "too many somersaults." By helping kill the bill, he kept the ACA intact and ESI's dominance unchallenged.

Bernie Sanders: Expanding the Waste Machine

In a presidential debate, Sanders declared healthcare a human right and that employers are responsible for providing insurance — ignoring that employees pay 100% of the cost through reduced wages. He champions expanding ESI, the $2 trillion-a-year waste machine, doubling down on a financing model that locks workers into jobs, hides costs, and prevents ownership of coverage.

The Benefit That Broke You — And Is Designed to Keep You That Way
How America's Employer-Sponsored Insurance Became the Greatest Financial Scam in Modern History — And How to Escape It

For decades, Americans have been told that employer-sponsored health insurance is a generous perk from bosses who care.
It's a lie — and one that's been costing you your wages, your freedom, and your future.

This book rips away the mask. You'll discover how a "benefit" born by accident during World War II was supercharged by tax loopholes, locked into place by politicians from both parties, and engineered to quietly siphon trillions from workers to insurers.

Inside, you'll learn:

- **The Myth of the Benefit** — Why you pay 100% of your premiums through reduced wages, no matter what your pay stub says.
- **The Incentive for Higher Costs** — How insurers profit when you get sick, and why they're rewarded for higher spending, not savings.
- **The ACA's Broken Promises** — How "reform" entrenched the employer-based model and made costs soar.
- **The Blueprint for Freedom** — How portable, age-based tax credits and Health Savings Accounts (HSAs) can give you ownership, lower costs, and build lasting wealth.
- **The Voluntary Revolution** — Why this change doesn't require mandates, political battles, or waiting for Congress — and how the system will unwind on its own once people have a real choice.

Drawing on history, economics, and insider knowledge, *The Benefit That Broke You* exposes the most expensive scam in American life — and shows you exactly how to walk away from it.

If you've ever felt trapped by your job for the sake of health coverage, wondered why your wages haven't kept up, or wanted a way to keep your money instead of handing it to insurers, this book will change how you see the system — and your power to leave it behind.

About the Author

Lee Benham has spent more than three decades in the insurance industry, helping individuals, families, and businesses navigate one of the most complex and costly systems in American life. In 2007, he became the first insurance agent to sell a Medicare Medical Savings Account (MSA) plan in the United States, giving him a front-row seat to how consumer-driven models can transform healthcare.

Drawing on years of real-world experience, Benham has worked with clients across the country, developed reform proposals adopted by policy advocates, and built financial strategies that put control back in the hands of everyday Americans. His deep knowledge of employer-sponsored insurance, healthcare policy, and Health Savings Accounts has made him a persistent voice for reform — and a fierce critic of a system that quietly drains trillions from workers while delivering less and less in return.

With *The Benefit That Broke You*, Benham blends history, economics, and insider expertise to expose the hidden costs of America's health insurance model — and to show a clear, practical path to freedom, savings, and ownership.

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