HEALTHCARE

Healthcare Should Follow People Through Life

Universal, comprehensive, affordable care as the standard - Medicare for All the clearest path, a Swiss-style bridge to get there - and the lead brief of a broader foundation.

PILLAR 3 · THE FOUNDATIONS OF A DIGNIFIED LIFE

AT A GLANCE

The problem

$4.9T a year, last of ten wealthy nations in results, 27.1M uninsured, 100M adults with medical debt.

The proposal

Universal, comprehensive, affordable care as the standard; Medicare for All the clearest path, a Swiss-style bridge to get there.

Cost & funding

Federal spending rises $1.5-3T/yr in CBO scenarios while national health spending stays flat or falls; a premiums-to-taxes shift.

Evidence strength

Strong on system failure (official scorekeepers); path costs are scenario-dependent and labeled as such.

Principal risk

Financing politics, and provider payment rates set wrong causing access shortages.

Success looks like

Uninsured rate tracked to zero; medical debt no longer a driver of financial ruin.

Summary

Healthcare is part of the basic infrastructure of a free life, and it should not depend on a person's job, wealth, age, or luck. The goal of this project is plain. Everyone covered, automatically, with coverage that follows you from job to job and year to year, care you can actually afford, and no family destroyed by medical debt. The end state is universal, comprehensive, and genuinely affordable healthcare: everyone covered for the full range of care - primary and preventive, mental health, dental and vision, maternal and reproductive, and long-term care - with no one priced out and no one bankrupted. Medicare for All - a single, publicly funded program covering everyone - is the clearest way to reach that standard, and the path this project favors; any universal system that truly meets the standard qualifies. Other wealthy countries reach universal coverage by several routes, single-payer like Canada, a national health service like Britain, and tightly regulated nonprofit multipayer like Switzerland, Germany, and the Netherlands; what they share is that everyone is covered, which is the standard, and the choice of vehicle is what this project holds open. Getting there from today's fragmented private system takes a bridge, and the clearest one is the Swiss model - everyone required to be covered, private insurers barred from profiting on basic care and required to accept all comers at community rates, and public subsidies so no one is priced out - which reaches universal coverage now, on structures we already have, and lays the foundation to move toward public, comprehensive care. What is not open to debate is the standard itself.

This is the lead brief of the Foundations of a Dignified Life, the pillar that treats healthcare, care, food security, education, and economic security as the ground on which freedom stands. Further foundation briefs will follow. Healthcare comes first because the failure is so visible and the cost of inaction so high: tens of millions uninsured, medical debt a major driver of financial distress, coverage that vanishes when someone changes jobs or gets sick, and rural hospitals closing across the country.

The Principle

Healthcare should follow people through life. It should not disappear because someone changes jobs, starts a business, gets sick, ages, or happens to live in the wrong county. A right to care means nothing without a system that delivers it, so this project commits to universal, automatic, portable coverage and treats the standard as non-negotiable. Everyone covered. Coverage that travels with you. Care you can afford. Medical debt no longer a thing that ruins lives. Primary care, prevention, mental health, dental and vision care, reproductive and maternal care, care for children and people with disabilities, eldercare, rural healthcare, and public health are not extras to be bought if there is money left over. They are infrastructure, and a serious country builds them the way it builds roads.

The System Failure

The American system already costs more than any other in the world and still leaves tens of millions without coverage and millions more a single illness away from financial ruin. The numbers are not close. The country spent $4.9 trillion on healthcare in 2023, $14,570 per person and 17.6 percent of the economy,[1] roughly double what comparable wealthy countries spend, and in the Commonwealth Fund's ten-country comparison the United States ranks last in overall health system performance while spending the most.[2] That money buys 27.1 million people no coverage at all, a number that rose by about a million in 2024,[3] and it leaves roughly 100 million adults carrying medical or dental debt, at least $220 billion of it.[4] A staggering share never reaches care in the first place: $812 billion a year, 34 percent of all health spending, goes to administration, about $2,500 per person against roughly $550 in Canada.[5] The question is not whether we can afford to cover everyone. It is whether we keep paying the way we do now, through premiums, deductibles, debt, untreated illness, and that administrative overhead, or build a system that simply covers people.

Several failures compound each other. Coverage is tied to employment, so losing or changing a job means losing care. In the states that declined to expand Medicaid, a coverage gap traps people who earn too much for traditional Medicaid and too little for subsidized insurance, and some of those states have spent real money on work-requirement programs that cost more to administer than they ever delivered in care.[6] Rural hospitals are closing across the country, taking maternity wards and emergency rooms with them,[7] and recent cuts threaten hundreds of millions more in rural-hospital revenue. The enhanced premium credits that made marketplace coverage affordable were allowed to lapse, and premiums jumped accordingly. Every one of these traces back to the same root. Coverage in America is conditional, fragmented, and easy to lose, when it should be universal and automatic.

The Proposal

The destination is universal coverage. The path runs through a national commitment and a set of immediate steps that get people covered along the way. This brief proposes six things.

1. **Commit to universal, comprehensive, affordable coverage.** Adopt the standard at the national level - covering primary and preventive care, mental health, dental and vision, and maternal care as core, not extras - and name the path. The comprehensive part is not decoration: traditional Medicare itself still excludes dental, hearing, and vision care, and the gap shows, with close to half of beneficiaries reporting difficulty hearing while only 8 percent used hearing services,[8] and out-of-pocket costs near $900 a year for those who do get dental or hearing care. Teeth, eyes, ears, and minds are part of the body; a system that covers everything below the neck and calls itself comprehensive is not. Medicare for All is the clearest destination and the one this project favors, though any universal system that meets the standard qualifies. The bridge is a Swiss-style universal system - a coverage requirement paired with regulated, nonprofit basic insurance and public subsidies - which reaches everyone now using the structures we already have, then moves toward public, comprehensive care. Judge every step by the same test: everyone covered, coverage that travels, comprehensive and affordable care, no medical-debt crisis, strong primary care, mental health, and rural capacity.

2. **Close the coverage gap.** As the immediate floor, create a federal route to coverage for the people stranded in the gap because their state declined to expand Medicaid, and strengthen the incentives for full expansion. No one should be uninsured because of a decision made in a state capitol they cannot control.
3. **Restore marketplace affordability.** Restore the enhanced premium tax credits that were allowed to lapse, since their expiration drove premiums up sharply and is projected to push large numbers of people off coverage. This is the most immediate lever available, because the price increase has already hit.
4. **Protect Medicaid and save rural hospitals.** Reverse the cuts threatening rural-hospital revenue, fund rural-hospital stabilization, and protect the coverage Medicaid provides, which in many places pays for a large share of births, of children's care, and of nursing-home care for seniors. Repeal the work-requirement mandate, using the documented record of those programs as the evidence that they function as paperwork barriers rather than work programs.
5. **Make primary care, mental health, and maternal care core.** Treat mental health as healthcare, expand primary and preventive care, and invest in maternal, reproductive, and pediatric care and in the rural workforce, so that having coverage actually means being able to reach care.
6. **Bring down the price of care.** Extend prescription-drug price negotiation, rein in the middlemen who mark up medicines, and ease the provider shortage through measures like debt relief for medical residents, so that universal coverage is also affordable coverage.

Reproductive Healthcare Is Healthcare

This platform's standard is universal, comprehensive care, and comprehensive includes reproductive care, stated without euphemism. The position: codify the Roe-era floor in federal law, protect contraception and IVF explicitly, and treat abortion access as the health and economic question the evidence shows it is. The largest study of its kind, tracking women for years after they sought abortions, found that those denied care were four times more likely to fall below the poverty line and three times more likely to be unemployed, more likely to stay tethered to violent partners, with worse outcomes for their existing children, while receiving care produced none of the predicted harms. Restrictions are associated with higher maternal mortality, and the states with the tightest bans carry, on average, the weakest maternal supports, a combination this platform's maternal-care planks exist to answer. The same paragraph belongs to veterans, because the VA is this brief's standing proof that public delivery works: systematic reviews consistently find VA care as good as or better than non-VA care, and the housing-plus-services HUD-VASH program has helped cut veteran homelessness by more than half since 2010. Finish that job to zero, and extend to every American the quality of public care the country already delivers to those who served.

The Financing Design

Outside reviewers correctly said the financing rhetoric needed a design, so here it is, stated as mechanism with the rates left honestly to official scoring rather than invented for effect.

The bridge design: maintenance of effort, converted. Employers already pay enormous premiums; the bridge does not pretend that money away, it redirects it. Employers currently offering coverage convert what they now spend on premiums into a per-worker healthcare contribution at approximately their existing average outlay, which then phases over several years into a standard payroll-based contribution, so no employer faces a cliff and the money that already funds care keeps funding care. Employees' premium payments convert the same way, below their current average. Employers not offering coverage phase into the payroll contribution with a small-business exemption at the bottom. Public subsidies continue for those outside employment. This is the design that honors the binding constraint most directly, since most families' new contribution is calibrated against what they already pay in premiums and out-of-pocket costs, and it is the messiest to administer, which the platform accepts as the price of a transition that does not yank anyone's coverage.

The end-state elements: wealth carries its share. As the system matures toward the public program, the financing tilts progressive: a surtax on the highest incomes, and the closure of preferences that let large fortunes escape tax entirely, beginning with stepped-up basis at death, consistent with the platform's tax-work-no-harder-than-wealth doctrine. These are named as real taxes, per The Ledger's rules.

What is deliberately not specified here: the exact percentages. Rates set in a brief rather than scored in legislation are theater. The commitments that bind instead: the financing must demonstrate, against independently reviewed household-type tables published before passage, that most working families pay less in new contributions than they now pay in premiums plus out-of-pocket costs, and until those tables exist this is a design requirement, not a proven result; the default structure is a progressive schedule with an exempted first band of wages, and no design advances that leaves below-median wage-earning households paying more than they do today, because the version-zero tables already show a flat rate failing exactly that household; provider payment rates are governed by the access metrics already named as this brief's falsifier; ERISA transition, Medicaid integration, and state maintenance-of-effort get resolved in the legislation with the same publish-the-tables discipline; and if the tables cannot be made to satisfy the family constraint, the design changes until they do, because the constraint is the promise.

Implementation Pathway

Universal coverage requires federal legislation. The clearest destination is Medicare for All, though any universal system that meets the standard can serve, and the bridge is a Swiss-style universal system that covers everyone first, so no one waits for care while the larger transition is built. The near-term floor moves faster. Closing the gap from the federal side and restoring the premium credits are legislative, and protecting Medicaid and rural hospitals runs largely through the appropriations and oversight process. Full Medicaid expansion remains a state decision, which is why the federal agenda centers on a fallback route to coverage rather than a mandate on the states.

Funding and Public-Value Logic

Universal coverage is not a new cost stacked on a working system. It is a redirection of money already being spent badly. The country already pays for the uninsured through emergency-room care, uncompensated care, lost productivity, and the $812 billion a year in administrative overhead that a fragmented system requires, and the states that closed their coverage gaps cut their uncompensated-care costs sharply. The Congressional Budget Office's own analysis of single-payer designs found that while federal spending would rise substantially, total national health spending would stay roughly flat or fall while covering everyone. Read that honestly: CBO's numbers are illustrative scenarios whose outcomes turn on provider payment rates, benefit design, cost sharing, and financing choices, not a prediction about any unspecified bill, which is why this platform commits to specifying those design choices as the legislation advances rather than waving the range as a promise. The full accounting, stated without flinching, is in The Ledger. Dollars aimed at coverage reach far more people than dollars aimed at verifying eligibility or propping up a fragmented insurance market. The return on coverage, in fewer emergencies, hospitals that stay open, healthier workers, protected pregnancies, and less debt, is larger and more durable than the alternative. Freedom that comes from stability is the dividend.

Risks and Guardrails

The standard is non-negotiable, and the transition runs in stages - universal coverage first through a Swiss-style system, then toward public, comprehensive care such as Medicare for All - so honesty about that path and its cost is part of the credibility. The answer to how we pay for it is that we already do, only worse. Whatever model is chosen, the transition should protect people's continuity of care rather than yank coverage out from under them, which is why automatic, portable enrollment is the design principle. Coverage also has to connect to care; a card with no hospital within an hour is not a health system, so coverage has to be paired with rural-hospital stabilization and workforce investment. And any work-requirement scheme should be judged by its measured results, which have consistently been tiny enrollment and administrative costs that dwarf the care delivered.

Metrics for Success

Judge the agenda on coverage, cost, and care.

- The uninsured rate, nationally and in rural areas, tracked toward zero, and the number of people in the coverage gap.
- Medical debt and its role in financial distress. • Rural hospitals open, in the red, or closed, and the status of maternity and emergency services. • Access to primary care, mental health, and maternal care, and maternal and infant outcomes. • Marketplace premiums and enrollment as tax-credit policy changes.
- For any work-requirement program, enrollment as a share of those eligible and the ratio of administrative spending to care.

Opposition and Responses

Some will call universal coverage unaffordable socialized medicine. The current system is already unaffordable, and we pay for it through premiums, debt, and waste rather than through coverage. Universal, automatic coverage can be built on the structures we already have, and the work-requirement experiments that some states ran as the alternative were themselves expensive government failures that spent more on bureaucracy than on care. Some will say this takes away private insurance. The bridge keeps private insurers - regulated and nonprofit for basic coverage, as in Switzerland - and even under Medicare for All, private supplemental plans continue, exactly as they do for people on Medicare today. What ends is a system where losing a job or getting sick means losing care. What it requires is that no one is left uninsured because they changed jobs, got sick, or live in the wrong place. Some will say work requirements promote responsibility. Most adults in the coverage gap already work. The records of these programs show the requirement functioning as a paperwork barrier that covered a small fraction of the eligible while spending the bulk of its budget on verification. And some will say a state cannot afford to expand coverage. It is already paying, through emergency-room costs, uncompensated care, and hospital closures. Expansion shifts most of the cost to the federal match and brings revenue to hospitals that are struggling. The expensive choice is the one many states are making now.

What Would Change Our Position

Be precise about what is falsifiable here. The standard, everyone covered, comprehensively, affordably, is a commitment, not a hypothesis. The path is a hypothesis, and evidence could redraw it: if a fully specified single-payer financing design showed most working families paying more than their current premiums and out-of-pocket costs combined, the financing design changes. If provider payment rates caused measurable access shortages in trials or early phases, rates change. If the Swiss-style bridge stalled short of universal enrollment or its regulated-nonprofit structure failed to control costs, the bridge loses its claim and a different vehicle carries the standard. The destination stays; every road to it is negotiable on evidence.

Public-Facing Language

Here is the short version. Healthcare should follow you through life. It should not depend on your job, your luck, or your zip code. Right now millions of people are one illness away from losing everything, coverage disappears the moment you change jobs, and rural hospitals keep closing. We can do better than keep patching a broken system. The goal is simple, and it is not radical. Everyone covered, coverage that follows you, care you can afford, and no family destroyed by medical debt.

SOURCES

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2. Commonwealth Fund, Mirror, Mirror 2024: ten-country health system comparison ↩
3. U.S. Census Bureau, Health Insurance Coverage in the United States: 2024 (P60-288) ↩

4. KFF Health Care Debt Survey ↩

5. Himmelstein et al., “Health Care Administrative Costs in the US and Canada,” Annals of Internal Medicine (2020) ↩

6. GAO report on Georgia Pathways: administration outspent care (GAO-25-108160) ↩

7. Commonwealth Fund on rural hospital closures and inpatient-care losses since 2010 ↩

8. KFF, dental, hearing, and vision costs and coverage among Medicare beneficiaries ↩
