



Healthcare in America — The Next Conversation Contents

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Part 1: What Does “Healthcare for All” Actually Mean?

A little over a year ago, I began a series called Healthcare in America, an attempt to understand how our current healthcare system was built and how it actually operates.

Over more than forty articles, we looked at the major parts of that system: hospitals, physicians, pharmaceuticals, insurance, Medicare, Medicaid, and the administrative structure that holds all of those pieces together.

That series was about understanding the system we have.

The question was simple:

How did we get here?

After spending that much time looking at healthcare in America, one thing became obvious. The healthcare debate often starts with the answer before we have agreed on the question.

One side says the answer is more government involvement.

Another says the answer is more competition and fewer restrictions.

Another says the answer is something in between.

But before we can decide which direction makes sense, we have to understand what we are actually trying to accomplish.

That brings us to the next conversation:

Where do we go from here?

The phrase we hear most often is:

Healthcare for All.

It is a phrase that sounds simple. It suggests a basic idea that most people can understand: people should be able to receive needed medical care.

The difficulty begins when we try to define what that promise actually means.

Does healthcare for all mean every person has an insurance card?

Or does it mean every person has access to medical care when they need it?

Those are related ideas, but they are not the same thing.

A person can have insurance and still struggle to find a doctor. They can have coverage and still wait months for an appointment. They can discover that the treatment recommended by their physician is limited by what their plan will pay for.

Insurance can help people access healthcare, but insurance itself is not healthcare.

That distinction is one of the places where the national conversation often becomes confused.

Healthcare is the doctor, the nurse, the hospital, the medication, the treatment, and the people who make those services possible.

Health insurance is the method we use to pay for those services.

The two work together, but solving one does not automatically solve the other.

A country can create a system where everyone has coverage and still face shortages of doctors, long waits, rising costs, or difficulty accessing care.

Providing payment for healthcare and delivering healthcare are two different challenges.

Once we understand that distinction, the phrase "Healthcare for All" becomes a much larger question.

Every healthcare system has to make decisions about what it promises, how it pays for those promises, and how it delivers them.

For example, a system must decide what level of care should be guaranteed to everyone. Is the goal basic medical services, or does the promise extend to things like dental care, vision care, mental healthcare, prescription medications, and long-term care?

Those decisions matter because every expansion of coverage also creates a need for more resources, more providers, and more funding.

Then comes the question that every healthcare discussion eventually reaches:

How do we pay for it?

This is where many political conversations become oversimplified. It is easy to say that healthcare should cost less or that someone else should pay more. It is much harder to design a system where the money actually covers the care people need.

Every healthcare system has a bill.

The difference is how that bill is collected and distributed.

Some systems rely more heavily on taxes. Some rely on employer contributions. Some rely on private insurance. Most countries use some combination of approaches.

The question is not whether society pays for healthcare.

Society always pays.

The real questions are who pays, how much they pay, and whether the system produces the results people expect.

There is another choice that often gets lost in the debate.

Who actually delivers the care?

A healthcare system can be publicly financed without having every doctor and hospital operated by the government.

It can also involve private organizations while still having strong government rules.

These distinctions matter because when people hear phrases like "government healthcare" or "private healthcare," they often picture completely different things.

A system is not defined only by who writes the check.

It is also defined by who provides the care, who makes decisions, and who is accountable when the system fails.

One advantage we have in this discussion is that we do not have to design a healthcare system from scratch.

Other countries have already tried different approaches.

They have made different choices.

They have experienced different successes and different problems.

There is no single universal healthcare model.

The United Kingdom, Canada, and Germany all provide broad access to healthcare, but they do so in very different ways.

The United Kingdom uses a National Health Service model where government plays a central role in both financing and delivering care.

Canada uses a single-payer model where government finances medically necessary care while many healthcare providers remain independent.

Germany uses a regulated multi-payer model where private and nonprofit insurers operate within national rules.

Each system reflects the priorities and compromises of the society that created it.

None is perfect.

That is an important point because healthcare debates often become a search for the perfect example. Supporters point to another country and say, "They solved it." Critics point to a different problem and say, "That proves it does not work."

The reality is more complicated.

Every system solves some problems better than others.

Every system creates tradeoffs.

The goal is not to find a perfect system.

The goal is to understand the choices.

That is where this conversation begins.

Before we decide what America should change, we need to understand what we are choosing between.

Healthcare is too important for slogans alone. It affects every family, every community, and eventually every one of us.

The question is not simply whether America should have more government involvement or less.

The real question is:

What kind of healthcare system can provide the care people need, at a cost society can sustain, while maintaining the quality and innovation people expect?

That is where this conversation begins.

In the next part, we will examine one of the most widely discussed proposals for changing American healthcare: Medicare for All.

Before deciding whether it is the answer, we first need to understand what the proposal actually means, what problem it is designed to solve, and what changes would be required to make it work.

Part 2 — Three Different Approaches to Universal Healthcare

Before we begin looking at different healthcare models around the world, I want to clarify the purpose of this section.

This is not an endorsement of any one system.

The goal is not to argue that the United Kingdom, Canada, or Germany has the perfect answer. Each system has advantages, disadvantages, supporters, and critics.

The goal is to understand how these systems actually work.

In future segments, these models will be referenced repeatedly. By understanding them now, we have a common reference point and can discuss real-world examples rather than relying on political slogans or assumptions.

This will be a joint journey.

The general path has been mapped out, but the individual parts have not been written in advance. As we explore these systems, new questions will arise, and those questions may shape where the conversation goes next.

If you discover this series later and are tempted to skip ahead looking for the final answer:

Spoiler alert: there isn't one.

The goal is not to find a simple answer that fits on a bumper sticker.

The goal is to ask a better question.

One that is based on reality, recognizes trade-offs, and may lead us toward a more reasonable and workable solution than another political promise.

Part 2A — The UK: Government-Run Healthcare (Beveridge Model)

If you want to understand what people mean when they talk about "socialized medicine," the United Kingdom's National Health Service, better known as the NHS, is probably the clearest example.

The NHS represents what is often called the Beveridge Model of healthcare.

The basic idea is simple:

Healthcare is a public service.

It is funded primarily through taxes, and care is provided based on medical need rather than a person's ability to pay.

In everyday terms, the phrase most associated with the NHS is:

Free at the point of use.

That does not mean healthcare costs nothing.

The cost was simply collected earlier, through the tax system, and pooled across society.

When someone walks into an NHS hospital, they are not asked about deductibles, insurance networks, or whether they can afford the treatment.

The system has already been funded.

How the NHS Began

The NHS was created in 1948, shortly after World War II.

Its foundation came from the Beveridge Report, which proposed rebuilding British society around a stronger social safety net after years of war and economic hardship.

The idea was straightforward:

Healthcare should function like other public services.

Just as a person does not prove their income before using a public road or entering a public school, they should not have to prove their ability to pay before receiving medical care.

Before the NHS, Britain had a much more familiar patchwork system:

Charity hospitals

Out-of-pocket payments

Limited insurance programs

Unequal access based on income

The NHS did not simply add another option.

It replaced that fragmented approach with a national system designed around universal access.

The Government Role: More Than Just Paying the Bills

This is where the NHS differs from Canada and Germany.

In many healthcare discussions, people use the phrase "government healthcare" loosely.

But in the NHS, the government role is much more direct.

The government does not simply finance the system.

It largely operates it.

Most hospitals are NHS-owned and operated.

Many doctors, nurses, and healthcare workers are NHS employees.

The NHS is one of the largest employers in the world.

Family doctors, known as general practitioners or GPs, are somewhat different. Many operate as independent contractors, but they work through NHS contracts and serve as the entry point into the system.

A typical patient experience looks something like this:

You register with a local GP practice.

The GP handles routine care, prescriptions, and referrals.

If you need specialized treatment, you are referred into the hospital system.

Emergency care is available through Accident & Emergency departments.

How the Money Works

The NHS is primarily funded through general taxation.

Most funding comes from sources such as:

Income taxes

Consumption taxes

Other government revenues

National Insurance contributions, which function somewhat like payroll taxes, provide additional funding.

Patient charges exist for some services, such as certain prescriptions, dental care, or optical services, but these represent only a small portion of overall NHS funding.

The government determines the overall NHS budget and sets national priorities.

This creates one of the system's greatest strengths and one of its greatest challenges.

With one major payer, the NHS has significant bargaining power.

It can negotiate drug prices, establish national standards, and reduce administrative duplication.

But because the government controls the budget, healthcare decisions become political decisions.

More money for healthcare means less money available somewhere else.

The Trade-Off: One System, Limited Resources

Like every healthcare system, the NHS faces the same basic reality:

Medical needs are unlimited.

Resources are not.

An aging population, new medical treatments, staffing shortages, and the effects of the COVID-19 pandemic have placed enormous pressure on the system.

The result has been growing concerns about waiting lists, particularly for non-emergency procedures.

Supporters point to the security the NHS provides:

No fear of a massive hospital bill

Equal access regardless of income

Strong bargaining power for controlling costs

Critics point to:

Waiting times

Budget pressures

Bureaucracy

Political influence over healthcare decisions

Both observations can be true.

The NHS provides universal access, but like every system, it must decide how to balance demand against available resources.

You will find a handy table in the accompanying text

The British Model in Simple Terms

The NHS combines:

Universal healthcare coverage

Tax-based funding

Government ownership of many healthcare facilities

Government employment of many healthcare workers

Central planning and budgeting

Limited private healthcare options alongside the public system

The defining feature is not simply that government pays.

It is that government plays the primary role in both financing and delivering care.

Comparison Reference: British Model

Question	United Kingdom NHS
Universal coverage?	Yes
Government owns hospitals?	Mostly yes
Doctors government employees?	Many yes, though GPs often contract independently
Single government payer?	Yes
Private insurance allowed?	Yes, for supplemental/private care
Main funding source?	General taxation
Government role?	Primary funder and primary provider

Part 2B — Canada: Single-Payer Healthcare

Canada is probably the healthcare model Americans hear about most often when the phrase "universal healthcare" enters a political conversation.

It is also probably the one most often misunderstood.

When many Americans hear "single-payer healthcare," they picture a government system where the state owns the hospitals, employs the doctors, and controls every medical decision.

That is not Canada.

Canada is a single-payer system.

The simplest way to understand that is this:

The government acts as the insurer.

It collects tax revenue and uses that money as one large public insurance pool. When a Canadian resident needs medically necessary healthcare — such as a hospital stay, surgery, or a visit to a physician — the patient generally does not receive a bill. The government pays the provider directly.

There are no competing insurance companies trying to sell you a different plan for those core services.

There is one primary payer.

The government.

One Country, Multiple Health Plans

Even the phrase "the Canadian government" needs some clarification.

Canada does not have one giant healthcare office in Ottawa managing every doctor's appointment.

Healthcare is primarily administered by the provinces and territories.

The federal government establishes the national framework through the Canada Health Act and provides funding support, but each province operates its own health plan.

The federal government essentially sets the ground rules.

Those rules require that provincial systems:

Cover all eligible residents

Be publicly administered

Provide access to medically necessary hospital and physician services

Allow coverage to follow residents when they move or travel within Canada

Avoid patient charges for insured services

If provinces fail to meet those requirements, the federal government can reduce funding.

The result is not one identical national program, but a collection of provincial systems that operate under the same basic principles.

What Does "Covered Healthcare" Actually Mean?

This is where the phrase "free healthcare" becomes more complicated.

Canada provides universal coverage, but not universal coverage of everything.

The key phrase is "medically necessary."

Hospital care, physician services, and certain diagnostic services are generally covered.

But outside those areas, coverage varies.

Prescription drugs taken outside a hospital, dental care, vision care, physiotherapy, long-term care, and many mental health services are often handled differently.

Some people receive coverage through employers.

Some purchase supplemental insurance.

Some qualify for provincial programs designed for specific groups, such as seniors, children, or low-income residents.

So when someone says, "Canadians have free healthcare," the more accurate statement is:

Canadians have publicly funded access to medically necessary hospital and physician care.

That distinction matters.

Canada removes the fear of receiving a massive hospital bill after an emergency, but it does not mean every healthcare-related expense disappears.

Public Money, Independent Providers

One of the most important things to understand about Canada is that single-payer does not mean government-run medicine.

Most Canadian doctors are not government employees.

Many operate independent practices or work in group clinics. They bill the provincial health plan according to negotiated fee schedules.

Hospitals are generally publicly funded nonprofit organizations that operate under government budgets rather than charging patients individually for every service.

In other words:

Public financing. Private delivery.

The government pays the bill, but the doctor is often still an independent professional.

This is why Canada is often used as an example by supporters of single-payer systems in the United States. The concept is not that government takes over every medical office. The concept is that one public insurer handles payment while providers continue delivering care.

The Trade-Off: The Waiting Room

Every healthcare system has trade-offs.

Canada's most common criticism is not usually access to emergency care.

If you are having a heart attack, you are treated.

The debate centers more around non-emergency care.

Specialist appointments, elective surgeries, and procedures that are important but not immediately life-threatening can involve waiting periods.

For many Canadians, the question is not whether they can eventually receive care, but how long they may have to wait.

That creates an ongoing debate within Canada itself:

How much should a system prioritize equal access?

How much additional capacity should be funded?

How much room should exist for private options?

These are not simple questions, and Canadians themselves continue to debate them.

The Canadian Model in Simple Terms

Canada combines:

Universal coverage for medically necessary hospital and physician services

One public payer

Independent doctors and healthcare providers

Provincial administration

Federal standards

Tax-based funding

Limited private insurance for additional services

It is not government-owned healthcare.

It is government-funded healthcare.

That difference is important.

Comparison Reference: Canadian Model

Question	Canadian System
Universal coverage?	Yes, for medically necessary hospital and physician services
Government owns all hospitals?	Generally no
Doctors government employees?	Generally no
Single government insurer?	Yes, for covered services
Private insurance allowed?	Yes, mainly for supplemental services
Main funding source?	General tax revenue

Question

Canadian System

Government role?

Primary payer and regulator

Part 2C — The German Model: Regulated Multi-Payer Healthcare

When most Americans hear the phrase "government healthcare," they often picture one thing: a government program that collects the money, owns the hospitals, employs the doctors, and makes the decisions.

Germany challenges that assumption.

Germany's healthcare system is not socialized medicine in the traditional sense. The government does not own the healthcare system, it does not employ most doctors, and it is not the single entity paying every medical bill.

Instead, Germany uses what is called a regulated multi-payer system.

At its core is a simple idea: everyone should have health insurance, but the insurance itself does not have to come from one government-run plan.

Health insurance has been mandatory for all residents since 2009. Roughly nine out of ten Germans receive their coverage through what are called statutory health insurance funds, often referred to as sickness funds. These are generally nonprofit organizations that compete with one another for members.

The remaining portion of the population, primarily higher-income earners above a certain income threshold, many self-employed individuals, and most civil servants, can choose private health insurance instead.

That distinction is important.

Germany does not say, "Everyone gets the same government insurance card."

Instead, it says, "Everyone must have insurance, and the insurance system must operate under national rules."

How the Money Works

This is where the German system begins to look very different from the American system.

For most workers, healthcare is financed through payroll contributions. Employees and employers share the cost, with contributions based on income rather than an individual's medical risk.

The money does not simply stay with the insurance fund that collected it.

Instead, contributions flow into a central national pool. From there, money is redistributed back to the individual sickness funds based on the health needs of their members.

Why does that matter?

Because without this system, competition between insurers could quickly become a competition to find the healthiest customers.

A company might try to attract young, healthy people while avoiding older patients or people with expensive medical conditions.

Germany's risk-adjustment system is designed to prevent that.

The goal is for insurance funds to compete based on service, efficiency, and patient satisfaction, not on how successful they are at avoiding people who need healthcare.

Two Paths: Public Insurance and Private Insurance

Germany actually has two insurance pathways.

The statutory system is based on solidarity. People contribute according to their ability to pay, and everyone covered receives a broad package of benefits.

Private insurance operates differently. Premiums are generally based on individual risk factors when someone joins, such as age and health status. Private insurers also build reserves intended to help cover higher costs later in life.

That creates a different set of tradeoffs.

Someone younger and healthier may find private insurance attractive because it can offer different options or pricing. However, as people age, healthcare costs generally rise, and changing insurers may become more complicated because a new insurer evaluates the person they are today, not the person they were when they first entered the system.

Again, the point is not that one approach is automatically better. It is that the systems operate under different philosophies.

Who Actually Runs Healthcare?

This is probably the most misunderstood part of the German model.

The German government establishes the legal framework, sets broad rules, and oversees the system.

But it does not directly manage every decision.

Many day-to-day decisions about benefits, quality standards, and payments are handled through a system of self-governance involving representatives from insurance funds, doctors, hospitals, and patients.

This approach has historical roots dating back to the 1880s under German Chancellor Otto von Bismarck.

That history is worth noting because it challenges another common assumption.

Germany's healthcare system was not created as an attempt to create a government-run medical system. It developed from a social insurance approach designed to provide workers with security and stability while maintaining a role for private providers and organized insurance groups.

The German Model in Simple Terms

Germany combines:

Mandatory universal insurance coverage

Multiple insurance providers

Private doctors and hospitals

Government regulation

Income-based financing

Competition between insurers

Rules designed to prevent insurers from avoiding expensive patients

It is neither a fully government-run healthcare system nor a completely free-market system.

It sits somewhere in between.

And that is precisely why it is useful as a point of comparison.

When Americans debate "healthcare for all," Germany reminds us that the debate is not simply a choice between government healthcare and private healthcare.

There are many possible designs.

The real questions become:

Who pays?

Who provides the care?

Who sets the rules?

Who takes the financial risk?

How much choice should patients have?

How much responsibility belongs to government, and how much belongs to the private sector?

Those questions will become increasingly important as we look at the other models.

Comparison Reference: German Model

Question	German System
Universal coverage?	Yes
Government owns hospitals?	Generally no
Doctors government employees?	Generally no
Single government insurer?	No
Private insurers allowed?	Yes
Multiple insurers compete?	Yes
Main funding source?	Payroll contributions
Government role?	Regulator and rule-setter

Part 2D — Three Answers to the Same Healthcare

After looking at the United Kingdom, Canada, and Germany individually, it helps to step back and compare the three systems side by side.

The purpose of this comparison is not to decide which system is "best."

Every healthcare system reflects choices about funding, access, responsibility, and trade-offs.

The question is not simply:

"Is healthcare government-run or private?"

The more useful questions are:

Who pays?

Who provides care?

Who sets the rules?

Who carries the financial risk?

What trade-offs does society accept?

These three countries all answered the same question: How does a society make sure people receive healthcare when they need it?

The United Kingdom answered with a government-run service.

Canada answered with a single public payer.

Germany answered with regulated competition among multiple insurers.

None of these systems is simply "government healthcare." That phrase is too broad to be useful.

They are different answers to the same question.

Question	United Kingdom NHS	Canada	Germany
Model Type	Government-run healthcare (Beveridge Model)	Single-payer healthcare	Regulated multi-payer healthcare (Bismarck Model)
Universal coverage?	Yes	Yes, for medically necessary hospital and physician services	Yes, through mandatory insurance
Who pays?	Government through general taxation	Government through tax-funded public insurance plans	Workers and employers through payroll-based contributions, plus other funding
Primary payer	Government	Provincial public insurance plans	Multiple nonprofit sickness funds and private insurers
Single government insurer?	Yes, for core NHS services	Yes, for covered medical services	No
Multiple competing insurers?	No	No, for core services	Yes
Government owns hospitals?	Mostly yes	Generally no; hospitals are publicly funded but often independently operated	Generally no
Doctors government employees?	Many are NHS employees; GPs often operate as independent contractors	Generally no; most are independent providers who bill public plans	Generally no; most are independent providers
How patients access care	Register with a GP, then referrals to specialists and hospitals	Present provincial health card; providers bill the public plan	Present insurance card; insurer pays providers
Private insurance allowed?	Yes, mainly for additional/private care	Yes, mainly for services outside the public system	Yes, including private coverage options for some groups
Main government role	Funder, owner, employer, and system manager	Primary payer and regulator	Regulator and rule-setter
Main strength often cited	Universal access with low financial barriers	Removes major medical bills while allowing independent providers	Combines universal coverage with competition among insurers
Main challenge often cited	Waiting times, budgets, political control	Wait times and gaps in drug/dental coverage	Complexity and balancing competition with regulation

Part 3 – Understanding the System Before Trying to Fix It

So far, we have looked at three healthcare models used around the world. Each has its strengths. Each has its weaknesses. None is perfect, and none mirrors the healthcare system we currently have in the United States.

One point that is often overlooked is that when we hear campaign slogans like "Universal Healthcare," it is rarely mentioned that the United States has already traveled part of that road. We already have Medicaid, a joint federal-state program designed for lower-income individuals and families. We also have Medicare, a federally administered program that primarily serves Americans age 65 and older, along with certain younger individuals who qualify because of disability or specific medical conditions.

What we do not have is a government-sponsored system that fully addresses the millions of Americans under age 65 who earn too much to qualify for Medicaid but still struggle to afford private health insurance. The Affordable Care Act—better known as Obamacare—was designed to help bridge much of that gap.

In Parts 3A, 3B, and 3C, I want to step away from politics and simply explain how our current system is organized. Before we decide what should change, we first need to understand what already exists.

This may seem like a lot of information, but I am condensing thousands of pages of federal laws, state regulations, insurance policies, and decades of changes into something the average person can understand. Even after studying it, I still find parts of it confusing. But before anyone can honestly say, "Here's how we should fix healthcare," we need a common understanding of what we already have.

As we work through these three sections, several larger questions will naturally emerge. Should healthcare be administered entirely by the federal government, or should the states continue to play a major role under federal guidelines? Should eligibility continue to depend on age, income, or some combination of both? Should we continue operating multiple programs, or would a more unified approach make better sense?

I'm not asking those questions because I already have all the answers. I'm asking them because they illustrate just how complicated healthcare has become. Before we can decide where we want to go, we first need to understand where we are.

Part 3A – Medicaid: America's State-Federal Safety Net

A look at the nation's healthcare program for lower-income Americans, how it is funded, how states administer it under federal guidelines, and why Medicaid can look very different depending on where you live.

Part 3B – Medicare: More Than Just Turning 65

An overview of Original Medicare, Medicare Advantage, Medigap, supplemental coverage, prescription drug plans, and why understanding the differences is often more confusing than people expect.

Part 3C – The Private Insurance System: Filling the Gap

An examination of employer-sponsored insurance, individual marketplace plans, the Affordable Care Act, and the millions of Americans who fall between Medicaid and Medicare while trying to navigate the private healthcare system.

Part 3A – Medicaid: America's Healthcare Safety Net

Before we can talk about changing America's healthcare system, we first need to understand one of the systems already in place.

Most people have heard of Medicaid. Fewer understand how it actually works. It is often described as "government healthcare," but that simple description leaves out an important fact.

Medicaid is not one single healthcare program.

It is a partnership between the federal government and the states.

Created in 1965, alongside Medicare, Medicaid provides free or very low-cost health coverage for lower-income Americans. Today, it covers roughly one in five people in the United States, making it one of the nation's largest healthcare programs.

The federal government establishes the basic rules, determines who must be covered, and shares the cost. Each state then operates its own Medicaid program, deciding many of the day-to-day details within those federal guidelines.

This is where the American conversation often goes sideways.

People hear "government healthcare" and picture one national system.

Medicaid isn't one system.

It's fifty programs wearing a trench coat.

The federal government lays the foundation by establishing minimum eligibility standards and required benefits. The states build on that foundation, deciding how their individual programs operate. Some even use different names. California calls its program Medi-Cal. Tennessee calls its TennCare. Different names, different administration, but built on the same basic framework.

Washington also helps pay the bills.

The federal government matches a percentage of each state's Medicaid spending. That percentage varies from state to state, with poorer states receiving a larger federal contribution than wealthier ones. For people covered under the Affordable Care Act expansion, the federal government pays an even larger share.

Who qualifies depends on more than simply having a low income.

Every state must cover certain groups, including children, pregnant women, many people with disabilities, some low-income parents, and many elderly individuals who also qualify for Medicare.

Where states differ most is in covering working-age adults.

Under the Affordable Care Act, states were given the option to expand Medicaid to include adults earning up to about 138 percent of the federal poverty level. Most states accepted that option. Others did not.

The result is something many Americans never realize.

Two people with nearly identical incomes and medical needs can receive very different treatment simply because they live in different states.

The same country.

The same federal law.

A very different outcome depending on which side of a state line they call home.

What Medicaid covers also follows this same partnership model.

Every state must provide core medical services such as hospital care, physician visits, laboratory work, nursing home care, family planning, and home health services.

Children receive especially comprehensive protection through a federal requirement that covers virtually all medically necessary care, including dental, vision, and mental health services.

Adult coverage varies much more.

Services such as routine dental care, vision care, expanded mental health treatment, and home-based long-term support are optional benefits that each state may choose to provide. Some states offer comprehensive coverage. Others provide only limited services.

Although Medicaid is often thought of as a program for low-income families, it quietly serves another critical role.

It is the nation's largest payer for long-term nursing home care and many home-based care services. For thousands of middle-class families, Medicaid eventually becomes part of the picture after years of savings have been exhausted by the cost of long-term care.

That reality often surprises people who assumed Medicaid was someone else's program.

Today, Medicaid and the related Children's Health Insurance Program (CHIP) provide coverage for roughly 74 million Americans.

It is one of the largest healthcare programs in the country.

It is also one of the least understood.

The Bottom Line

Medicaid demonstrates that healthcare in America is already a shared responsibility between the federal government and the states.

That partnership allows states to tailor their programs to local needs, but it also creates significant differences depending on where someone lives.

Whether those differences represent flexibility or inequality depends largely on your perspective.

For now, the important point is simply this:

Before discussing how America's healthcare system should change, it helps to understand that we already have a large, successful, and remarkably complex public healthcare program operating in every state.

The question is not whether government has a role in healthcare.

It already does.

But Medicaid is only one example of government involvement in American healthcare. The next program takes a different approach, covering people not because of income, but primarily because of age.

Part 3B – Medicare: More Than Just Turning 65

Before we can talk about changing America's healthcare system, we need to understand another major piece of the system already in place.

Most Americans have heard of Medicare. Many are enrolled in it. Others have helped a parent, spouse, or friend navigate it. Almost everyone has heard the basic explanation: when you turn 65, you go on Medicare.

That explanation is not wrong.

It is just incomplete.

Medicare is much more than a healthcare program for people over 65. It is a large and complex system that has evolved over nearly sixty years, combining federal government coverage, private insurance options, and individual choices.

Like Medicaid, Medicare was created in 1965 as part of the expansion of healthcare coverage in America. But while Medicaid is a partnership between the federal government and the states, Medicare is a federal program with the same basic rules across the country.

Whether someone retires in Oregon, Ohio, or Oklahoma, Medicare operates under the same federal framework.

That is one of the biggest differences between Medicare and Medicaid.

Medicaid is primarily based on income and need.

Medicare is primarily based on age, disability status, and certain medical conditions.

Most people qualify because they reach age 65. Others qualify because they have received disability benefits long enough to meet Medicare requirements, or because they have specific conditions such as end-stage kidney disease or ALS.

Your bank account does not determine eligibility.

Your age or medical circumstances do.

Medicare Is Not One Single Program

This is where Medicare becomes more complicated.

Many people assume Medicare is simply one insurance plan provided by the government. In reality, Medicare is a collection of different parts that cover different areas of healthcare.

It is a little like being handed several menus at a restaurant and being told to build your own meal. The choices are there, but understanding how they fit together is not always simple.

The major pieces are Parts A, B, C, and D.

Part A: Hospital Coverage

Part A is often called hospital insurance.

For most people, there is no monthly premium because they already paid into the system through payroll taxes during their working years.

Part A helps cover major medical events, including:

- Inpatient hospital stays
- Limited skilled nursing facility care after a qualifying hospital stay
- Hospice care

However, like almost every part of healthcare, the word "covered" does not mean every expense disappears. Deductibles and other cost-sharing requirements still apply.

Part B: Medical Coverage

Part B covers many of the healthcare services people use outside the hospital.

This includes:

- Doctor visits
- Outpatient services
- Preventive care

Medical equipment such as walkers, wheelchairs, and other medically necessary devices

Unlike Part A, Part B generally requires a monthly premium. Most people pay a standard amount, although higher-income beneficiaries may pay more through income-related adjustments.

Together, Parts A and B make up what is commonly called Original Medicare.

But that is only one way to receive Medicare coverage.

This is where Medicare begins to look less like a single program and more like a collection of choices.

Two Paths Through Medicare

Once someone enrolls in Medicare, they have an important decision to make.

They can stay with Original Medicare and add supplemental coverage, or they can choose Medicare Advantage.

Both approaches are part of Medicare.

They simply organize coverage in different ways.

Original Medicare

Original Medicare includes Parts A and B.

One of its biggest advantages is flexibility. A person with Original Medicare can generally see any healthcare provider in the country who accepts Medicare. There are no traditional insurance company networks limiting choices in the same way many private plans do.

The tradeoff is that Original Medicare does not cover every cost.

There can be deductibles, coinsurance, and other out-of-pocket expenses. In many situations, Medicare pays its share and the patient is responsible for the remaining amount.

That is where Medigap enters the picture.

Medigap is private supplemental insurance designed to help cover some of the expenses that Original Medicare does not pay. The federal government standardizes many Medigap plans, meaning that a Plan G from one insurance company provides the same basic benefits as a Plan G from another company.

The differences are usually the monthly premium, customer service, and the reputation of the insurance company.

For many people, Original Medicare combined with a Medigap policy provides predictable costs and broad freedom to choose providers.

Medicare Advantage

Medicare Advantage, also called Part C, takes a different approach.

Instead of receiving Medicare benefits directly through the federal government, beneficiaries choose a private insurance company approved by Medicare to manage their coverage.

These plans often combine:

- Hospital coverage
- Doctor coverage
- Prescription drug coverage

Many also include additional benefits that Original Medicare does not normally cover, such as dental, vision, hearing benefits, and wellness programs.

For many people, that combination is attractive.

Some Medicare Advantage plans have very low monthly premiums, sometimes even no additional monthly premium beyond what they already pay for Medicare Part B.

But lower premiums can involve tradeoffs.

Most Medicare Advantage plans use provider networks. Some services may require prior authorization, meaning the insurance company reviews the request before agreeing to pay for certain tests, procedures, or treatments.

The advantage is that these plans include a yearly limit on out-of-pocket costs, something Original Medicare does not provide by itself.

The choice between Original Medicare and Medicare Advantage often comes down to priorities.

Some people value flexibility and the ability to see almost any Medicare provider.

Others prefer the convenience of having more benefits combined into one plan.

Neither choice is automatically right or wrong.

They simply represent different ways of balancing cost, flexibility, and control.

Part D: Prescription Drug Coverage

Prescription medications became another major part of Medicare with the creation of Part D in 2003.

People with Original Medicare can purchase a separate Part D prescription drug plan. Many Medicare Advantage plans include prescription coverage as part of their package. Because private companies administer these plans, each one has its own list of covered medications.

A prescription that is inexpensive under one plan may cost much more under another.

This is why choosing a Medicare plan involves more than looking at the monthly premium. The medications someone takes and the doctors they use can be just as important.

What Medicare Does Not Cover

One of the most common misunderstandings about Medicare is that once someone turns 65, all healthcare expenses are covered.

That is not how Medicare works.

Medicare generally does not cover many services that people often assume are included, such as:

- Routine dental care
- Routine vision care
- Hearing aids
- Long-term nursing home care

Those gaps are one reason some older Americans need additional coverage or eventually qualify for Medicaid as well.

Medicare may cover medical treatment.

Medicaid may help with services Medicare does not cover.

Together, they demonstrate how different parts of America's healthcare system overlap.

The Bottom Line

Medicare is one of the largest and most important healthcare programs in the United States.

It provides coverage for millions of Americans and has become a familiar part of retirement planning.

But Medicare is not a single government insurance plan.

It is a system built over decades, combining federal rules, private insurance options, private healthcare providers, and personal decisions.

Understanding Medicare helps explain one of the larger challenges in American healthcare.

The debate is often presented as government versus private healthcare.

The reality is more complicated.

America's healthcare system already contains both.

Before we decide what healthcare in America should become, it helps to understand what it already is.

Medicare is one more piece of that puzzle.

Part 3C – Private Insurance: The System Most Working Americans Use

If you're of working age, earning too much to qualify for Medicaid, and not yet old enough for Medicare, chances are this is the healthcare system you live in.

Unlike Medicaid and Medicare, private health insurance is not run by the government. It is offered by private insurance companies, although the government establishes many of the rules they must follow. For most Americans, there are really only two ways to get it.

Door Number One: Your Employer

This is how most working Americans receive health insurance.

Roughly 150 to 165 million people under age 65 are covered through an employer-sponsored plan, making it the single largest source of health insurance in the United States.

For many people, it feels almost automatic. You accept a job, fill out a few forms during orientation, choose one of the available plans, and health insurance quietly becomes another payroll deduction.

What many people never see is what that coverage actually costs.

While an employee may contribute around \$120 a month toward individual coverage, the total cost of that insurance is often several times higher. The employer pays most of the premium behind the scenes. Family coverage can cost well over \$25,000 a year, with employers absorbing much of that expense.

That arrangement works well—as long as the job continues.

One downside of employer-sponsored insurance is that the coverage is tied to employment. Leave the job, retire early, or get laid off, and the insurance usually goes with it. COBRA allows many people to continue the same coverage temporarily, but now they pay the entire premium themselves. For many families, that is the first time they discover what their health insurance actually costs.

Like every other part of the American healthcare system, employer plans also vary. Deductibles, provider networks, prescription drug coverage, and out-of-pocket costs can differ significantly from one employer to another.

Door Number Two: Buying Your Own Insurance

Not everyone has access to employer coverage.

Self-employed workers, gig workers, early retirees, and people whose employers do not offer affordable insurance often purchase coverage through the Affordable Care Act Marketplace, either through HealthCare.gov or a state-operated exchange.

Marketplace plans all provide a common set of essential health benefits. They include hospital care, physician services, prescription drugs, preventive care, maternity care, and mental health services. Just as important, insurance companies cannot deny coverage or charge higher premiums because someone has a pre-existing medical condition.

Plans are grouped into four metal tiers:

Bronze

Silver

Gold

Platinum

The names sound impressive, but they simply describe how costs are shared.

Bronze plans generally have the lowest monthly premiums but the highest deductibles and out-of-pocket costs. Gold and Platinum plans usually require higher monthly premiums while reducing what you pay when you actually need medical care.

It is really a trade-off between paying more now or paying more later.

For many Americans, federal premium tax credits help reduce the monthly cost of Marketplace coverage. Those subsidies are based primarily on household income.

As of 2026, however, the enhanced subsidies available in previous years have expired. Financial assistance is less generous than it once was, and households whose income rises above certain limits can lose eligibility for premium assistance altogether.

The result is that two families buying exactly the same insurance policy may pay dramatically different premiums simply because their incomes fall on opposite sides of the subsidy rules.

The People in the Middle

This is the part of the healthcare system that serves millions of Americans who fall between Medicaid and Medicare.

They earn too much to qualify for Medicaid.

They are too young to qualify for Medicare.

If employer coverage is available, many enroll through work.

If it is not, they shop for insurance on the Marketplace.

Others purchase private insurance without financial assistance.

And some simply go without coverage, hoping they stay healthy because they cannot comfortably afford the alternatives.

The Bottom Line

Private insurance is the foundation of healthcare coverage for most working Americans.

Unlike Medicaid, eligibility is not based primarily on income.

Unlike Medicare, eligibility is not based on age.

Instead, coverage depends largely on employment, individual purchasing decisions, and the ability to afford premiums, deductibles, and other out-of-pocket costs.

For many Americans, private insurance works well.

For others, it can be expensive, confusing, or difficult to maintain when life changes.

Like Medicaid and Medicare, it solves some problems while creating others.

Understanding how private insurance works completes the picture of America's three major healthcare systems—and helps explain why healthcare reform is rarely as simple as a campaign slogan suggests.

Veterans and Medicare: Why You Probably Need Both

One more piece of America's healthcare system deserves its own discussion.

This one is not a fourth major healthcare program like Medicaid, Medicare, or private insurance. Instead, it is an example of how different healthcare systems can overlap.

If you're a veteran receiving healthcare through the Department of Veterans Affairs (VA), one of the biggest questions you'll eventually face is surprisingly simple:

"If I already have VA healthcare, do I really need Medicare?"

Many veterans assume the answer is no.

The VA itself says otherwise.

In fact, the Department of Veterans Affairs strongly encourages eligible veterans to enroll in Medicare Parts A and B when they become eligible. That advice surprises many people, but it makes sense once you understand how the two systems work.

Two Separate Healthcare Systems

The first thing to understand is that VA healthcare and Medicare are completely separate programs.

They do not coordinate benefits the way two private insurance companies sometimes do. They do not split the bill. One does not automatically pay what the other leaves behind.

Instead, each system operates independently.

If you receive care at a VA medical center or through VA-authorized community care, the VA pays according to its rules. Medicare is generally not involved.

If you receive care from a physician or hospital outside the VA system that accepts Medicare, Medicare pays according to Medicare's rules. The VA generally does not reimburse those costs simply because you are a veteran.

The responsibility for deciding which system you are using rests largely with you.

That may sound complicated, but it is simply the result of two independent healthcare systems serving the same person.

Why Medicare Part B Still Matters

One of the most expensive mistakes a veteran can make is assuming that VA healthcare replaces Medicare.

It does not.

VA healthcare is not considered creditable coverage for Medicare Part B.

That means if you delay enrolling in Part B because you already receive care through the VA, Medicare may impose a permanent late-enrollment penalty if you decide to enroll later. The penalty increases your monthly premium for as long as you have Part B.

For that reason, the VA itself recommends that most eligible veterans enroll in Medicare Parts A and B when they first become eligible.

Doing so preserves your options.

If you need care while traveling, want to see a specialist outside the VA system, or simply prefer a non-VA provider for a particular medical issue, Medicare gives you that flexibility.

Prescription Drugs Are Different

Prescription drug coverage follows different rules.

VA prescription drug benefits are considered creditable coverage for Medicare Part D. As long as you maintain your VA drug coverage, you can generally delay enrolling in a Part D plan without facing the late-enrollment penalty.

Many veterans continue using VA pharmacies because prescription costs are often very low, particularly for service-connected conditions.

As with the rest of the healthcare system, however, the best choice depends on individual circumstances, including where you receive care and which medications you take.

How Medicare Options Fit In

The Medicare choices discussed earlier still apply to veterans.

If you choose Original Medicare, a Medigap policy can help pay deductibles and coinsurance for Medicare-covered services received outside the VA system. It does not apply to care provided through the VA because Medicare is not involved in those claims.

If you choose a Medicare Advantage plan, the plan covers your non-VA healthcare according to its own provider network and rules, while your VA benefits remain available separately. Some Medicare Advantage plans even market additional benefits specifically to veterans, but those plans should be evaluated carefully to be sure their provider networks meet your needs.

Using Both Systems

Many veterans eventually develop a practical routine.

They rely on the VA for care related to service-connected conditions, routine medical care, prescription medications, and services the VA provides particularly well.

At the same time, they keep Medicare available for healthcare outside the VA system, including physicians closer to home, specialists, emergencies, or care received while traveling.

Rather than replacing one another, the two programs complement each other.

The Bottom Line

VA healthcare is one of the nation's most valuable healthcare resources for eligible veterans.

But it was never designed to replace Medicare.

The two programs serve different purposes, follow different rules, and operate independently.

Understanding how they work together gives veterans greater flexibility, helps avoid unnecessary penalties, and makes it easier to receive care when and where it is needed.

Like so much of America's healthcare system, the goal is not choosing one program over another.

It is understanding how the pieces fit together.

Healthcare For All, The Evolving Series

Before We Go Any Further

Before we get too far into how healthcare for all could actually work, let's look at two examples from opposite ends of the spectrum.

One is a system that, by most measures, worked remarkably well. The other is a system that started with good intentions and a legitimate goal, but failed because we didn't follow through.

We'll do the home run first.

It's almost a fairy tale come true. Or, more likely, Asgard with the Thunder Gods in charge.

In 1969, Norway discovered oil in the North Sea. The Norwegians made a decision that would eventually define much of their future: the wealth generated by that resource belonged to the country, not to a handful of people who happened to own the wells.

They didn't spend it all at once. They built a system around it, eventually creating one of the world's largest sovereign wealth funds and using the proceeds as part of a broader social contract with the Norwegian people. Norway still follows that basic philosophy today.

Their healthcare system isn't quite as simple as saying, "It costs you \$300 a year and the government picks up the rest." But the basic idea is surprisingly close.

Norwegian residents generally pay modest user fees for many healthcare services. Once those approved payments reach the annual ceiling, the government-issued exemption card means they no longer pay those user fees for covered services for the remainder of the year. In 2026, that ceiling is NOK 3,278. Hospital admissions in public hospitals carry no user fee.

Why does it work?

Well, Norway has a few advantages we don't.

Norway is small. Norway is wealthy. Norway has a relatively homogeneous population and a much smaller healthcare system to manage. And Norway isn't a global superpower with a massive military, industrial, infrastructure and healthcare complex supporting more than 340 million people.

They have a lot of cod to dry, but they don't have quite as much country to run.

So I'm not suggesting we simply copy Norway.

That's not the point.

The important part is the commitment.

Norway made a decision that the country's natural resources were part of the country's future, not simply an opportunity for whoever happened to control them. They built institutions around that decision and have continued to maintain them through changes in government and economic conditions.

They have even been trying to reduce their dependence on the very fossil fuels that made them wealthy, with enormous investment in electric vehicles, renewable energy and other technologies.

That doesn't mean Norway is perfect. Far from it.

Their wind-energy expansion has produced its own political and environmental battles, including concerns about the effect of wind farms on reindeer grazing areas and Indigenous Sámi interests.

Apparently even the Thunder Gods have to deal with zoning disputes.

We wouldn't want anything happening to Rudolph's red nose, now would we?

But Norway illustrates something important.

A commitment is only a commitment if you keep it after the applause dies down.

Now let's look at the other example.

This one happened here at home.

Good Intentions Are Not Enough

In 1963, President John F. Kennedy signed the Community Mental Health Centers Act. The idea was to move mental-health treatment away from large, isolated institutions and toward community-based care.

There were good reasons for doing it.

Many state psychiatric hospitals had become terrible places. Abuse, neglect, overcrowding and dehumanizing conditions were not imaginary problems. New medications offered new possibilities for treating people outside institutions, and the

growing civil-rights movement was rightly challenging the idea that people with mental illness could simply be warehoused indefinitely.

The goal wasn't wrong.

The problem was what happened next.

The federal government encouraged deinstitutionalization and envisioned a network of roughly 1,500 community mental-health centers. But the promised community infrastructure was never fully built, and funding for many services did not keep pace with the people being released from institutional care.

States also faced increasing pressure to reduce the cost of institutional care. Over time, many facilities closed and responsibility shifted toward outpatient care, Medicaid, local governments and other systems.

But there was a problem.

You can't simply close the hospital and assume the community will magically take its place.

A person with severe schizophrenia doesn't necessarily become capable of living independently because the state hospital closes its doors.

Someone who needs medication management, supervision, housing, food, transportation and continuing psychiatric care doesn't stop needing those things because we have decided that institutionalization is no longer acceptable.

The alternative has to exist before the old system disappears.

And too often, it didn't.

Oregon provides a particularly painful example.

The state closed Dammasch State Hospital in Wilsonville in 1995. Later, Oregon's Eastern Oregon Psychiatric Center in Pendleton closed in 2014, further reducing the state's institutional capacity.

And to be fair, the old psychiatric hospitals had serious problems. Some were places no civilized society should have tolerated.

But there is a lesson here that applies far beyond mental health:

When something is broken, we have a tendency to cut it instead of fixing it.

We close the hospital.

We eliminate the program.

We reduce the budget.

We declare victory.

And then we discover that the problem didn't disappear.

It simply moved somewhere else.

The Dry Statistics

The numbers are difficult to ignore.

HUD reported that 771,480 people experienced homelessness on a single night in January 2024, an 18 percent increase from 2023 and the highest number recorded in that annual count.

Mental illness is not the only cause of homelessness. Housing costs, addiction, poverty, domestic violence, unemployment and other factors all play major roles.

But serious mental illness is unquestionably part of the problem.

And when a person with severe mental illness has nowhere to live, nowhere to receive continuing treatment and no one capable of managing the system around them, the alternatives can become remarkably predictable.

The emergency room.

The psychiatric hospital.

The jail.

The sidewalk.

Then back around again.

That's not a healthcare system.

That's a revolving door.

And that brings us back to healthcare for all.

I'm not using Norway as proof that America can simply copy Norway.

We can't.

Nor am I using the failure of America's mental-health deinstitutionalization effort to argue that government healthcare can't work.

That would miss the point entirely.

I'm using these two examples because they illustrate two things we need to understand before we go any further.

The first is what happens when a country makes a long-term commitment to its citizens and continues to honor that commitment.

Norway decided that certain things were simply part of the social contract.

Healthcare is one of them.

The second is what happens when we start down a path with good intentions but fail to build the infrastructure necessary to reach the destination.

The goal doesn't change simply because the first attempt didn't work.

You fix the problems.

You don't abandon the goal.

There will be hiccups. There will be mistakes. There will be unintended consequences. There will be politicians screaming that the whole thing is a disaster.

That's politics.

The question is whether we have enough commitment to keep working on the problem anyway.

Because if we aren't willing to make that commitment up front—if we're only willing to support healthcare for all as long as it is easy, inexpensive and politically convenient—then there isn't much reason to continue the discussion.

Healthcare for all isn't just a question of designing a system.

It's a question of whether we are willing to finish what we start.

So What Would Healthcare for All Actually Look Like?

We talk about healthcare for all as though America doesn't have any healthcare at all. The talking voices on television can certainly make it sound that way, but as we have seen, we actually have an enormous and fairly robust healthcare system. It has its faults, some of them serious, but it provides medical care to hundreds of millions of people through several different programs, insurance systems and funding mechanisms.

What is lacking is coverage for the people who make too much for Medicaid, aren't disabled, and are too young for Medicare. Some of them have employer-provided private insurance, some buy insurance through the Affordable Care Act, and some have no insurance at all. This is the group that lives in the middle, between the government programs we already have and the private insurance system.

We have looked at three systems that provide universal healthcare: Germany, the United Kingdom and Canada. All three have entirely different structures, and although government plays a major role in each, they ultimately depend on their respective taxation systems to pay for healthcare. There isn't one magic formula for universal healthcare, and there certainly isn't one that we can simply pick up and drop into the United States.

The fourth example we looked at was Norway, which is a little different. Norway is a social democracy that maintains a capitalist, free-market economy, but a large portion of its national wealth comes from oil production in the North Sea.

In 1969, Norway discovered oil in the North Sea, and the Norwegians made a decision that would eventually define much of their future: the wealth generated from that resource belonged to the country, not simply to the people who happened to control the wells. They didn't spend it all at once. They built a system around it, eventually creating one of the world's largest sovereign wealth funds and using the proceeds as part of a broader social contract with the Norwegian people.

We will come back to that later, because there is another question worth asking: why do the natural resources of our nation benefit so few people rather than the country itself? But that is another discussion.

For now, let's get back to us.

We already have Medicaid, Medicare and the Veterans Health Administration. We have employer-sponsored private insurance, the Affordable Care Act marketplaces and millions of people who purchase insurance on their own. We also have millions of people who remain uninsured.

So if we are going to add another layer to cover everyone in between, what do we do about the systems we already have? Do we scrap everything and build one new system that covers everybody, or do we leave the existing systems in place and build something around them?

And when I say everybody, I really do mean everybody. Children, poor people, working people, unemployed people, young people, old people, disabled people and veterans, whether they were physically wounded during their service or came home carrying other consequences of their time in uniform. If the goal really is healthcare for all, then eventually we have to decide what those words actually mean.

Will we finally start treating mental illness as healthcare instead of treating it as somebody else's problem? What about homelessness and drug addiction? They are citizens too, and they need medical care. How much care would be provided, and where would the limits be? Would there be an annual maximum on what an individual could be required to pay out of pocket, or would there be limits on how much care the system itself would provide?

These aren't easy questions to ask, and I assure you the answers are going to be even harder to come by.

So when you hear a campaign speech promising “healthcare for all,” you might want to ask a simple question: How are you going to do it? And then perhaps ask the even more important question: Do you actually know?

Should We Combine Everything?

That is the question I started asking myself. If we are serious about creating healthcare for everyone, does it make sense to combine Medicaid, Medicare, veterans' healthcare and the private insurance system into one enormous program?

There are some obvious advantages. A single system could be easier to manage because there would be fewer separate sets of rules and administrative systems. It could potentially be easier to fund and could make it easier to identify and control waste, duplication and fraud. The same hospitals and doctors could serve everyone under the

same basic system, and instead of carrying different insurance cards and dealing with different rules depending on who you are, there could be one common system.

There is also the possibility that combining some of these functions could reduce administrative costs. We already spend an enormous amount of money moving healthcare dollars through multiple insurance companies, government programs, state agencies and administrative systems. If some of that duplication could be eliminated, perhaps more of the money could actually reach the people providing the care.

But there is a downside, and it is a pretty big one.

The same thing that makes a combined system easier to manage could also make it easier for a change in government policy to screw the whole thing up.

That's a real concern. Governments change, administrations change, Congress changes and budgets change. If everything is tied together into one enormous system, a bad decision at the federal level could affect virtually everybody at the same time.

That raises the possibility that perhaps we shouldn't combine everything after all.

Maybe Medicare should remain Medicare. Maybe Medicaid should remain Medicaid. Maybe the Veterans Health Administration should remain a separate system because veterans have a unique relationship with the federal government that is different from ordinary health insurance.

Perhaps instead of tearing down the systems that already cover hundreds of millions of Americans, we should build a new system specifically for the people who currently fall into the middle.

In some ways, that would be an extension of what the Affordable Care Act was attempting to accomplish, except rather than simply helping people purchase private insurance, we would create an actual healthcare system designed to provide coverage for the people who currently depend on the private insurance market or have no coverage at all.

That approach would be less disruptive to the people already covered by Medicare, Medicaid and veterans' healthcare. It would also give us an opportunity to design the new system from the ground up around the people it is intended to serve.

Of course, there is a downside to that approach as well. We would be creating yet another healthcare program, with another funding mechanism, another bureaucracy, another set of rules and another opportunity for waste, confusion and corruption.

So we haven't solved the problem.

We've simply moved it.

And that may actually be the point of this exercise. Before we decide how to pay for healthcare for all, we need to decide what healthcare for all is actually going to look like.

And Then There Is the Money

The next big question we will have to explore is who pays for it.

The short answer is you. It will always be you, because you are the government. That's a simple answer, and I know it, so don't start throwing tomatoes yet. Put them in a basket so I can make soup.

The real answer is considerably more complicated, because Americans are already paying an enormous amount of money for healthcare. We aren't starting from zero, and that is something that often gets lost in the political argument.

We already pay for Medicare through taxes and premiums. We already pay for Medicaid through federal and state taxes. Employers spend money on health insurance for their employees, and employees contribute to those plans as well. Millions of people pay insurance premiums, deductibles and copayments, while taxpayers also subsidize portions of the Affordable Care Act marketplace.

So if we build something new, we aren't simply adding the entire cost of American healthcare to the existing bill.

At least, we shouldn't be.

The real questions are much more complicated. Which taxes would fund it? Would everyone pay the same amount, or would people pay according to their income? What happens to the money employers currently spend on employee health insurance? What happens to the premiums and deductibles people currently pay? What happens to the taxes already supporting Medicare and Medicaid? Would some of those costs disappear, or would we simply move them from one pocket to another?

And then there is the question of the states.

Medicaid is jointly funded by the federal government and the states, with the federal government paying a different percentage depending on the state. If a new system followed something similar, the quality or level of coverage could vary depending on where you live because some states simply have more money than others.

On the other hand, if the entire system were federally funded, the argument would immediately be made that taxpayers in wealthier states were now paying for healthcare for people in poorer states.

Fair or not, that is going to be part of the discussion.

The point I am trying to make is that there isn't going to be an easy answer. We can talk about healthcare for all as a wonderful goal, and perhaps it is. But eventually somebody has to design the system, somebody has to administer it, somebody has to pay for it, and somebody has to decide what happens when it doesn't work as intended.

So maybe the best course is to leave the systems we already have largely intact and develop another healthcare system specifically for the people who currently fall into that middle ground, the people the Affordable Care Act was designed in part to help but who still depend primarily on private insurance.

That would add another layer of bureaucracy, another funding system and another opportunity for waste and corruption. But it might also be the least disruptive way to move toward universal coverage without putting the systems that millions of Americans already depend upon at risk.

I don't know yet which approach makes the most sense.

And I'm not sure anybody else does either.

But that is what we are going to explore.

Because if somebody tells you they have already solved healthcare for all, you might want to ask them to explain the details.

The details are where the real healthcare debate begins.

Part 5 – Where Does the Money Come From?

In any healthcare system, sooner or later we have to ask the big question: where does the money come from?

It's easy to say, “From the taxpayers,” and yes, ultimately that is true. But that's not really an answer. The more useful question is how the money gets from all of us into the healthcare system, because as we've already seen, there isn't one answer.

We already have several healthcare systems operating in the United States, and they don't all get their money the same way.

Veterans Healthcare

Veterans' benefits and healthcare are funded primarily by the federal government. The Department of Veterans Affairs administers those programs, while Congress provides the funding through the federal budget.

Some veterans' benefits, such as disability compensation and pensions, are generally treated as mandatory spending, meaning that the government is obligated to pay eligible recipients under the law. VA medical care, including hospitals, clinics, medical research and administration, is funded primarily through congressional appropriations.

There are other sources of revenue, including some insurance reimbursements, copayments and third-party billing, but those are relatively small compared with the federal funding that supports the Veterans Health Administration.

So, for practical purposes, veterans' healthcare is a federal responsibility, paid for through the federal government.

Medicaid

Medicaid is different.

Medicaid is jointly funded by the federal government and the states. The federal government provides matching funds to the states, with the federal share determined in large part by the Federal Medical Assistance Percentage, or FMAP. Wealthier states generally receive a smaller federal match, while states with lower per-capita incomes receive a larger federal share.

The states provide the remaining portion of the funding, and in some states local governments also contribute.

The states administer their own Medicaid programs within federal requirements, while the federal government provides funding and oversight.

So Medicaid is essentially a partnership between the federal government and the states.

Medicare

Medicare is different again.

Medicare is federally administered and has several different funding streams.

Medicare Part A, which covers hospital care and related services, is funded primarily through the Medicare payroll tax. The familiar 1.45 percent Medicare tax withheld from an employee's paycheck is matched by another 1.45 percent from the employer, for a combined 2.9 percent. Higher-income workers can also pay an additional Medicare tax.

Parts B and D work differently. They are funded primarily through general federal revenues and beneficiary premiums, with additional sources of revenue involved in the prescription drug program.

And there is an important distinction here because people sometimes think the Social Security tax and Medicare tax are one big pot of money because both appear on the same paycheck under FICA.

They aren't.

The Social Security payroll tax funds Social Security. The Medicare payroll tax funds Medicare's Hospital Insurance Trust Fund. They are legally and financially separate programs, although there are some interactions between the two systems, including revenue from the taxation of Social Security benefits that contributes to Medicare.

So, in very simplified terms, we already have three different answers to the question "Who pays?"

Veterans' healthcare is primarily federally funded.

Medicaid is jointly funded by the federal government and the states.

Medicare uses dedicated payroll taxes, general federal revenues and beneficiary premiums, depending on which part of Medicare we're talking about.

Three major programs. Three different funding structures.

And somehow the lights stay on.

That is worth sitting with for a minute, because it means the idea of creating another funding stream isn't nearly as radical as it might sound.

The question isn't whether we can create another stream.

The question is how.

The Obvious Answer

The obvious answer is the one nobody particularly wants to hear: another line item in the payroll tax, paid by both employees and employers.

We already know how that mechanism works. Medicare is partly funded that way, and a new healthcare program for the people currently living in the middle could theoretically be financed through another payroll contribution.

It would be relatively straightforward.

It would also be another tax.

And while that may eventually be part of the answer, I don't think it should automatically be the first answer we reach for.

There is another idea worth considering.

I brought up Norway earlier because of something more important than its healthcare system. Norway made a decision about the wealth generated from its natural resources. Rather than treating that wealth simply as an opportunity for whoever extracted it, the country created a mechanism through which a substantial portion of that wealth could benefit the country as a whole.

We have a smaller example of that idea right here at home.

Alaska has the Alaska Permanent Fund, created from the state's oil wealth. The fund is designed to preserve a portion of the value generated from Alaska's natural resources for the benefit of future generations rather than allowing all of that money to simply disappear into the annual operating budget.

That brings me to an idea I have been thinking about.

What If the Resource Belongs to the People?

I'm not talking about nationalizing the oil companies.

The companies that explore for the oil, drill the wells, build the pipelines, operate the equipment and take the enormous risks involved in extraction deserve to make a profit. I'm not arguing otherwise.

But profit and ownership are not necessarily the same thing.

The company can own the equipment. It can employ the workers. It can invest billions of dollars. It can take the risks and earn a return on that investment.

But the oil, natural gas, minerals and other resources were underneath the ground before the company arrived.

So perhaps we should ask a different question.

What if the natural resources of the United States were treated as a public asset, with the American people receiving a return when those resources are extracted?

I'm not suggesting that we simply tax the companies more heavily.

I'm suggesting something conceptually different: a public return on a public resource.

The resource would remain available for private companies to develop. They would still make money. They would still compete. They would still own their businesses and equipment.

But a portion of the value of the resource itself would be returned to the public.

And rather than allowing that money to become another pot of money for politicians to spend every year, perhaps it could be placed into a protected national investment fund, similar in principle to what Norway has done and, on a smaller scale, what Alaska has done.

The purpose wouldn't be to fund every government program that happens to need money. It would be an investment in the country itself. Healthcare could be one use. Infrastructure could be another. Education, disaster preparedness, retirement security or other long-term national needs could eventually be considered.

The important part would be that the money belongs to the people, not to whichever administration happens to occupy the White House or whichever party happens to control Congress. It would be protected, as much as anything created by government can be protected, from being raided whenever politicians need money for the next political priority. The purpose would be to build something that lasts beyond an election cycle.

And before someone labels the idea socialist, let's be clear about what I'm actually suggesting.

I'm not suggesting public ownership of corporations.

I'm not suggesting that the government take over the oil companies, mining companies or energy companies.

I'm suggesting public ownership of the natural resource itself and a public return when someone extracts it.

That's a very different proposition.

Whether it is a good idea is another question entirely.

I'm not presenting it as the answer to healthcare.

I'm presenting it as something worth thinking about.

Back to Healthcare

Healthcare is expensive, and the costs aren't distributed evenly across the country. Providing healthcare in a rural community can be considerably different from providing it in a mid-sized city or a major metropolitan area. There are differences in hospital availability, physician shortages, transportation, demographics, wages and the cost of maintaining facilities.

The variables are endless.

That means whatever system we eventually design is going to have to account for those differences. A funding formula that works perfectly in Portland isn't necessarily going to work perfectly in rural Oregon, Montana or Mississippi.

And that brings us back to where we started.

There is no magic pot of money sitting somewhere waiting for us to discover it.

Ultimately, healthcare is paid for by the people of this country, whether that money reaches the system through payroll taxes, income taxes, employer contributions, premiums, state budgets, federal appropriations or some other mechanism.

The question is how we collect it, how we distribute it and whether we can build a system that spends it wisely.

Maybe the answer is another payroll tax.

Maybe it is some combination of existing taxes and contributions.

Maybe a national resource investment fund could eventually provide part of the answer.

Maybe it is something we haven't thought of yet.

What I don't think we can do is look at the complexity, decide it's too confusing and walk away.

Because if we do that, nothing changes.

And if we are serious about healthcare for all, then eventually we have to be willing to sit down, put all the numbers on the table and figure it out.

It won't be easy.

But “it's too complicated” isn't really an answer.

It's just another way of saying we decided not to try.

Part 6 – Wait a Minute

We've spent a lot of time looking at what other countries have done, what we already have here in the United States, how our existing programs work and, in Part 5, how we currently pay for them. We've looked at Medicaid, Medicare and Veterans healthcare, and we've looked at the private insurance system that covers the enormous group of Americans who fall somewhere in the middle.

And after all that, I think I may have been looking at this from the wrong mountain.

I started this series thinking about what we would have to build to create healthcare for everyone. I was thinking about hospitals, doctors, nurses, insurance, government programs, funding and all the other pieces that would have to be assembled into some enormous new system.

Then I stopped and thought about it.

Wait a minute.

Maybe we already have most of it.

We have the hospitals, the doctors and the nurses. We have specialists, pharmacies, laboratories, physical therapists, rehabilitation facilities, mental health professionals and thousands of private clinics. We have an enormous medical infrastructure already operating in every part of the country. We have Medicare, Medicaid and Veterans healthcare already paying for medical care for millions of Americans, and we have private insurance covering millions more.

So perhaps the question isn't whether America has the ability to provide healthcare.

Perhaps the question is who gets to use the system, and how do we pay for it?

That changes the discussion considerably.

The easiest and potentially most dangerous approach would be to design one enormous new system that covers everyone and replaces everything we currently have. It sounds good on paper, and I might have argued for exactly that when I started this project back in Part 1.

The more I learn, the less attractive that idea becomes.

We already have millions of people depending on Medicare, Medicaid and Veterans healthcare. Those systems aren't perfect, but they are functioning systems, and people

depend on them. I don't think we should put those people at risk simply because we have decided that the system needs to change.

So rather than tearing everything down and starting over, what if we built the missing piece?

Medi for Everyone Else

I'm going to call it Medi for Everyone Else for now, because I haven't thought of a better name and because the name explains the basic idea.

Instead of replacing Medicare, Medicaid and Veterans healthcare, we create another federal medical insurance program designed primarily for the people who currently depend on private insurance or have no insurance at all.

That would include the enormous number of working-age Americans who don't qualify for Medicaid and aren't old enough for Medicare. Most of them already have private insurance, generally through an employer, while others purchase insurance themselves or remain uninsured.

And this is where something else becomes possible.

We don't necessarily have to combine everything immediately.

Medicare could remain Medicare. Medicaid could remain Medicaid. Veterans healthcare could remain Veterans healthcare. Medi for Everyone Else could be built as a separate program and allowed to work out its problems without disrupting the programs that are already providing care.

Over time, the systems could become more compatible. The transition from Medicaid into the new system, or from the new system into Medicare, could eventually become much more seamless. We could even look at what happens when people move from one program to another so that changing eligibility doesn't also mean changing doctors, pharmacies and an entire set of rules.

This would cost more money in the beginning because we would be adding something rather than immediately eliminating something else.

But there is an advantage to that.

We could learn as we go.

If something doesn't work, we fix that part without bringing the entire healthcare system down with it.

That matters because healthcare isn't just doctors and hospitals. It is an enormous ecosystem of people, businesses and institutions that depend upon one another. There are rural hospitals that are already struggling, private clinics, specialists, pharmacies, laboratories, medical equipment companies, administrators and thousands of other businesses supporting the system.

There is also mental healthcare, something I don't think we have come close to solving. It seems that our national strategy has too often been to ignore mental illness and hope it goes away.

Spoiler alert: it doesn't.

It is right there in homeless encampments, on the streets, in emergency rooms, in jails and prisons, and in families that don't know where to turn. If we are serious about healthcare for everyone, mental healthcare can't remain the forgotten stepchild of the system.

And there is another potential advantage to having several publicly supported programs working toward the same basic goal.

Bargaining power.

Medicare already has enormous purchasing power when it comes to prescription drugs. Now imagine Medicare, Medicaid, Veterans healthcare and Medi for Everyone Else negotiating together.

Instead of four programs buying independently, they could potentially act together when negotiating prices for drugs, equipment and other services.

I'm not saying that would automatically work. I'm saying it is something worth investigating.

The same principle applies to administration. There may be places where combining functions makes sense and places where keeping them separate makes more sense.

And that brings us back to something we discussed earlier: perhaps the long-term goal should eventually be one system, but the path to get there should be deliberately slow.

In the long run, one comprehensive system might reduce administrative costs, eliminate some duplication and provide greater equality in coverage. But getting there in one giant leap would create an enormous opportunity for failure.

I'd rather see us take one step, make sure it works, take another step and keep going. Build it as a living program. Let it grow. Let it respond to the needs of the people it serves.

After all, if it is going to be healthcare for the people, then it should be something owned by the people.

It isn't a gift from Washington.

It was never Washington's to give.

Part 7 – The Elephant in the Room

So now we've come around the mountain and discovered that we may not need to rebuild the entire healthcare system after all.

We have most of the infrastructure already. We have the people, the hospitals, the medical technology, the knowledge and the need. We are already spending enormous amounts of money on healthcare.

So what are we really talking about?

Insurance.

And that is where I think the real battle begins.

I'm going to admit something here. When I started this series, I said I wasn't going to make it about politics. I was wrong.

Not because this should become a partisan argument. It shouldn't.

I'm talking about something bigger than Republicans and Democrats. I'm talking about the political machinery itself and the enormous amount of money and influence surrounding healthcare.

Healthcare should not be a political football. It is too important, and it affects too many people. This country exists because of its people; the people do not exist to serve the political system.

If we ever decide that healthcare for everyone is something worth doing, then it cannot be something that gets turned on and off every time the White House changes hands.

That is why I keep coming back to the idea of protecting the existing programs while we build something new.

It may cost more at first. It may not be the most efficient way to get there. But it gives us something we don't have if we put everything into one giant system on Day One: **a margin for error.**

If one piece doesn't work, we fix that piece. If one funding mechanism doesn't work, we change it. If one service needs to be redesigned, we redesign it. We don't knock over the entire row of dominoes.

The Money Is Already Here

This is where Part 5 comes back into the discussion.

I don't want to pretend that I have figured out the exact tax structure or financing formula. I haven't, and I don't think I should pretend that I have. Those are the kinds of questions that people who actually understand federal taxation, budgeting and public finance need to work through.

But I do think we should stop talking as though America has to suddenly find an enormous pile of money that doesn't already exist.

We already spend **trillions of dollars every year on healthcare.**

So perhaps the first question shouldn't be, "Where are we going to find all this new money?"

Maybe the first question should be:

How much are we already spending, where is it coming from, where is it going, and what are we getting for it?

That's a different question.

It also leaves open the possibility that some of the money already being spent could be redirected, consolidated or used more efficiently.

And there may be other sources of public wealth worth considering as well, such as the public-resource investment idea we discussed in Part 5.

I'm not claiming that oil royalties or a national investment fund will suddenly pay for American healthcare.

I'm saying we should be willing to ask the question.

If a portion of the nation's natural resources creates wealth, should some portion of that wealth be returned to the people who collectively own the resource?

Maybe.

That's a discussion for people who know how to design those systems.

My job here is simply to put the question on the table.

And Then There Are the Insurance Companies

If we are going to create a new federal medical insurance program, we cannot pretend the existing insurance industry won't notice.

They will.

There is an enormous amount of money involved in American healthcare, and private insurance companies are deeply embedded in the way the system currently operates.

I don't think we should underestimate the fight that would come from that industry and its lobbying organizations.

We've seen this before.

Look at the tobacco industry. We knew for decades that nicotine and tar were dangerous. Yet an industry with enormous financial resources fought regulation, influenced public policy and worked to protect its business interests.

I'm not comparing tobacco companies to health insurance companies.

I'm pointing out something much simpler: **when enormous amounts of money are involved, enormous amounts of money will be spent trying to influence what happens next.**

Dark money, lobbying, campaign contributions and political pressure don't suddenly disappear because the issue is healthcare.

So what do we do about the existing insurance companies?

I originally wrote that they should partner with the federal government.

I'm not sure that's the right way to describe it anymore.

Perhaps the better answer is that they should have a choice.

If a private insurer wants to participate in administering the basic federal program, it could compete to do so under federal rules, with structured and transparent fees and consistent requirements. The government program would pay for the service rather than the individual policyholder.

If an insurance company doesn't want to participate, that's fine too.

It could continue to sell supplemental coverage, gap insurance and other private plans to people who want additional coverage beyond the basic federal benefit.

In other words, private insurance doesn't necessarily have to disappear overnight.

But it also doesn't get to remain the gatekeeper for basic healthcare simply because that's the way we've always done it.

That distinction matters.

The goal isn't to destroy an industry.

The goal is to change what that industry is being paid to do.

And if private insurance can find a useful role in the new system, let it compete for that role.

If it can't, then the market will have to decide what happens next.

This Cannot Belong to One President

There is another problem, and I think it may be one of the most important.

A program like this cannot be built around one president, one Congress or one political party.

It would take years to build. Maybe a decade. Maybe longer.

That means the structure has to be designed from the beginning to survive political change.

When I say "independent," I don't mean an agency that answers to nobody. I mean an organization with enough structural protection that it cannot simply become a political party favor for whoever happens to occupy the White House or for whichever politicians helped create it.

The people running it should have qualifications for the job. Terms should be structured so that one president cannot simply replace everyone. Its finances should be transparent. Congress should have oversight. There should be rules governing how it operates, and changing those rules should require more than one administration deciding it wants something different.

Independent should actually mean **independent**.

Not independent until the next president gets annoyed. Not independent until someone decides they need the money for their favorite project. Not independent until a political donor wants a favor.

The program needs to belong to the people who are paying for it and depending upon it.

That doesn't mean politicians disappear from the process.

It means the basic healthcare structure should be harder to manipulate for short-term political purposes.

Start Small, Learn, Keep Going

I don't think we can accomplish this in one pass.

We shouldn't even try.

The idea would be to start with basic medical coverage, build the system, test it, find the failures and fix them.

Then we could add additional services as the system becomes financially and administratively stable. Dental and vision are obvious candidates. Mental healthcare needs considerably more attention. Physical therapy and rehabilitation, specialist care and other services can be evaluated as we go.

The point is not to create a perfect system on the first day.

The point is to create a system that can **improve without collapsing**.

I've been thinking about those domino demonstrations where one little piece starts a chain reaction and, if everything is positioned correctly, the entire thing works.

They look simple when you watch them.

But behind that simplicity is an enormous amount of planning. Every domino has to be in the right place and the sequence has to work.

Healthcare is like that.

We can't see the entire chain from where we are standing. There will be pieces we get wrong. There will be things we didn't anticipate. There will be unintended consequences.

So we need safety mechanisms.

If one piece falls the wrong way, it shouldn't bring down the entire system.

And that brings me back to where I started this series.

I said at the beginning that I wasn't going to have **The Answer**.

I still don't.

What I hoped to do was ask better questions.

Maybe we've gotten there.

Because I don't think the question anymore is simply, "Should America have healthcare for all?"

That's too easy.

The questions are much harder.

What should be covered? Who should administer it? Who should pay for it? What happens to the systems we already have? What happens to the people who work in the existing system? What happens to private insurance? How do we protect the program from political interference? How do we pay for it without simply pretending the money doesn't matter?

And perhaps most importantly:

How do we build something that can survive us?

Not just one president. Not one Congress. Not one political party. Not one generation.

Something that can be adjusted, repaired and improved as the country changes.

Because if we are going to call it healthcare **for all**, then perhaps the commitment needs to be for all of us, including the people who haven't been born yet.

And that's a much bigger commitment than putting four words on a campaign sign.

Part 8 Where Do We Go From Here?

I love music, but I don't really have a clue what is good or bad. I know what I like. I've always enjoyed listening to Bonnie Tyler belt out "Holding Out for a Hero," and maybe that's what we need now, not necessarily a hero in the way we usually think of one, but someone who can see the possibilities here and is willing to take up the fight.

It doesn't have to be someone with billions of dollars. It could be someone with a voice that reaches millions of people. It could be someone with the resources to put an idea in front of people who would never otherwise see it. It could be someone who simply has enough credibility that people will stop and listen when they say, "Maybe we ought to think about this."

Because that's really what I'm talking about.

I'm not looking for someone to finance a national healthcare system. Nobody could do that. I'm looking for someone who can help make the conversation bigger than it is today.

Those of you who have read this far may already see possibilities here. You may disagree with some of what I've written. You may have questions I haven't answered. You may see problems I haven't considered. Good. That's what should happen.

If you come back and read this again, challenge what I've said. Ask questions. Talk about it with someone else. Tell me where you think I'm wrong. That's how ideas develop. That's how new discussions begin. And sometimes, that's how change comes about.

It comes back to priorities.

There are people in this country who have accumulated more wealth than they could possibly spend in several lifetimes. I hear the call, "Tax the oligarchs." Maybe that's the answer to some problems. Maybe it isn't. But what we're talking about here is much bigger than what any individual's tax bill could pay for.

We aren't talking about finding a few trillion dollars today and calling the problem solved. We're talking about building something that would have to work year after year, generation after generation.

So when I think about what enormously wealthy people could do, I don't necessarily think first about writing a check to pay for healthcare. I think about what happens when

someone with enormous resources decides to use some of that wealth, influence and public visibility to champion a cause.

We've already seen examples of what substantial private resources can accomplish when they are directed toward problems that governments and institutions have struggled to solve. Nobody expects a private individual or foundation to finance American healthcare. That's not the point.

The point is influence.

Imagine someone with enough money to open doors, enough credibility to be taken seriously and enough determination to keep talking about an idea long after the news cycle has moved on.

Or imagine someone without that kind of wealth but with a voice that millions of people will listen to.

Maybe that's the hero we need.

Maybe the person who takes up this cause hasn't even thought about it yet.

And perhaps instead of asking only what the very wealthy can do with another tax break or another luxury purchase, we should occasionally ask a different question: What could they do to help protect and improve the country that helped create the wealth and power they enjoy?

Maybe sometimes paying it forward is a better investment than buying the next supercar or the next thirteen-million-dollar ski chalet.

I'm not asking for donations. This isn't about me. Your donations to me wouldn't make any difference in establishing a Medi healthcare system for everyone anyway.

What I'm asking for is something much harder to put a price on: attention.

Someone willing to say, "This deserves to be discussed."

Someone willing to keep saying it after the first week.

Someone willing to bring other people into the conversation.

Someone willing to challenge the idea, improve it, find what doesn't work and help build something better.

We've spent this entire series looking at healthcare from different directions. We've looked at what other countries do. We've looked at what America already has. We've looked at how those systems work and how we currently pay for them. We've looked at what might be possible without tearing everything down and starting over.

And I've tried very hard not to tell you that I have The Answer.

I don't.

Maybe I've done something more useful.

Maybe I've simply put an idea on the table.

If it is a good idea, somebody else can pick it up, challenge it, improve it and carry it farther than I ever could.

And if it isn't a good idea, then I hope somebody tells me why.

That's the way this is supposed to work.

It doesn't belong to Democrats.

It doesn't belong to Republicans.

It doesn't belong to any political label.

It belongs to the people who would have to live with whatever we eventually build.

So maybe the question isn't whether there is a hero out there.

Maybe the question is whether there is someone willing to become the voice for an idea that might be worth pursuing.

Any heroes out there?

Medicare for All Sounds Simple

The healthcare plan currently being proposed under the name Medicare for All sounds wonderful. Universal coverage. No premiums. No deductibles. No copays for most covered care. One system for everyone.

The problem isn't necessarily the goal. The problem is the size of the change.

The current House and Senate bills are not simply an expansion of Medicare or a public option. They would create a national single-payer system and largely replace employer insurance, individual insurance, Medicaid, CHIP and the ACA marketplace. Private insurers would generally be limited to supplemental coverage. The proposed transition is remarkably short—roughly two years.

Think about what that means. Private insurance companies aren't simply going to say goodbye to the enormous premium business they have built. They would have to transform their businesses almost overnight. Employers would redirect money they currently spend on health insurance. Employees would redirect what they currently pay. Government programs would be absorbed or replaced. And then the federal government would have to become the payer for virtually everybody.

The funding proposal follows the same basic philosophy: redirect the enormous amount of money already being spent on healthcare while adding new taxes and other federal revenue. Supporters argue that eliminating much of the insurance bureaucracy and negotiating prices could make the system less expensive overall. Critics argue that the tax increases and transition costs would be enormous. Those are important arguments, but they are almost secondary to the practical question: Can you actually move an entire country from one healthcare system to another in two years?

Then there is politics.

The current Medicare for All legislation is overwhelmingly a Democratic proposal. There is no Republican support for it, which means it begins with essentially no bipartisan foundation. And politics matters. A senator or representative isn't necessarily eager to vote for a massive restructuring of one-sixth of the American economy if the other party gets to claim the credit for it.

Interestingly, Hakeem Jeffries, who previously sponsored Medicare for All legislation, now says he does not support the current proposal. Asked about it recently, he said it is

not legislation he currently supports, while continuing to argue that America needs to find a way to fix its broken healthcare system. His public comments have instead emphasized restoring and strengthening existing programs, including the Affordable Care Act and Medicaid.

Of course, his critics immediately accused him of selling out to the insurance industry. That is politics talking. You don't have to agree with Jeffries to understand what he is saying: fix what we have before we attempt to replace everything we have.

And that brings me back to the reason I started this series in the first place.

Healthcare is not a campaign slogan. It is not one program. It is not one insurance card. It is an enormous collection of hospitals, doctors, pharmaceutical companies, insurers, employers, government programs, patients, regulations, subsidies and billions of dollars moving in thousands of directions every day.

There is no magic phrase—"Medicare for All," "Repeal Obamacare," "private insurance," or anything else—that makes all of that disappear.

And there is one more thing voters need to remember: campaign promises are not legally binding.

A candidate can promise you virtually anything to get your vote. Once elected, they still have to get legislation through Congress, find the money, write the regulations, negotiate with the people affected and somehow get the system to work.

So when somebody promises to fix healthcare, don't just ask whether it sounds good.

Ask how.

Where does the money come from? Who pays? Who gets paid? What happens to the people and businesses already in the system? How long does it take? What happens during the transition? What happens when something goes wrong?

If the person making the promise can't give you a reasonably good answer to those questions, they may have a great campaign slogan.

They may not have a healthcare plan.

The answer to America's healthcare problem isn't going to come exclusively from the left or the right. Ultimately, it will come from the people demanding something more useful than a slogan: specifics.

Retirement and That Piggy Bank, Your Home

Here is something many people approaching retirement probably should know, but may never have thought about.

Your home may be your largest retirement asset. And in some parts of the country, what was once an ordinary middle-class house has become an extraordinarily valuable asset.

Over the past several decades, and particularly during the housing boom surrounding and following the COVID years, real estate values in many areas have risen dramatically. A house purchased 20 years ago for \$300,000 might today sell for \$550,000, \$700,000 or considerably more.

I have seen an even more dramatic example in the Seattle area, where a house originally purchased for around \$300,000 eventually sold for just under \$800,000.

I can give you two examples from my own history.

I bought a 1,300-square-foot Craftsman home in Torrance, California, in 1975 for \$32,000. Today, Zillow estimates that same house at roughly \$1.6 million.

And then there is the house I sold in 1967 for, again, \$32,000. It was in Manhattan Beach, one block from the ocean. Zillow now puts the value of that property at roughly \$5.5 million.

Those are real numbers.

And they help explain something you see in expensive parts of the country: homes that have been in families for generations are often passed from one generation to another rather than sold. The family may not be able to afford to buy a comparable house today, but selling the old one can mean giving up an asset they could never replace.

But that isn't really the point of this sidebar.

The point is what can happen when you finally decide to turn some of that home equity into retirement money.

Your House Can Affect Your Medicare Bill

Medicare has something called IRMAA — the Income-Related Monthly Adjustment Amount. It is an additional charge added to Medicare Part B and Part D premiums for people whose income is above certain levels.

And here is the part that catches people by surprise:

Medicare is looking at your income, not your net worth.

You can have a \$2 million house and relatively modest retirement income and not owe IRMAA because of the house.

But sell that house and realize a large taxable gain, and suddenly the income picture can change.

The IRS generally allows a homeowner to exclude up to \$250,000 of gain on the sale of a qualifying primary residence, or up to \$500,000 for a qualifying married couple filing jointly. But that is an exclusion of gain, not a blanket exemption from all the consequences of a profitable sale. Any gain that cannot be excluded can become taxable income.

And that is where retirement planning gets interesting.

Suppose a married couple has owned a home for many years and realizes a \$700,000 gain when they sell it. If they qualify for the \$500,000 exclusion, there could still be \$200,000 of gain that is potentially taxable.

Now add Social Security, pension income, IRA withdrawals, 401(k) withdrawals, investment income and other taxable income.

That one home sale could push their income into a completely different Medicare bracket.

The Medicare "Cliff"

For 2026, an individual with Medicare who has modified adjusted gross income of \$109,000 or less generally pays the standard Part B premium.

For a married couple filing jointly, the threshold is \$218,000.

But go even one dollar over the applicable threshold and you move into the next IRMAA bracket. That doesn't mean you pay a surcharge on that one extra dollar. It means the higher premium applies to the entire Medicare year. That's why people sometimes describe IRMAA as an income "cliff."

For 2026, the standard Part B premium is \$202.90 per month. In the first IRMAA bracket, the Part B surcharge is another \$81.20 per month, and the Part D surcharge is another \$14.50 per month for people who have prescription drug coverage.

That's \$1,322.40 a year in additional Part B and Part D premiums for one person if both apply.

And that is only the first step. The higher-income brackets become substantially more expensive.

There is another wrinkle that makes this particularly easy to miss.

Medicare generally looks back two years.

For 2026 premiums, Social Security generally uses information from your 2024 federal tax return. So you could sell your house in 2024, pay whatever taxes are due, move on with your life — and then discover in 2026 that your Medicare premiums have gone up because of that earlier income.

In other words, you may have forgotten about the home sale by the time Medicare catches up with it.

And Then There Are Your Retirement Accounts

The house isn't the only thing that can push you over an IRMAA threshold.

Traditional IRAs and 401(k)s are another potential problem.

Once required minimum distributions begin, money coming out of traditional tax-deferred retirement accounts generally becomes taxable income. And that income is included in the calculation Medicare uses for IRMAA.

This creates an interesting retirement-planning problem.

You may have spent your working years putting money into tax-deferred accounts because that was financially smart at the time. But eventually the government wants its tax money, and those withdrawals can affect more than just your income-tax bill.

They can also affect what you pay for Medicare.

So What Can You Do?

This isn't a "do this and save thousands" situation. Everyone's circumstances are different. But there are planning tools worth knowing about.

One is Roth conversions. Before required minimum distributions become a major factor, some people gradually move money from traditional IRAs into Roth IRAs and pay the tax along the way. Done carefully, this can reduce future RMDs.

But there is a catch: the conversion itself creates taxable income in the year you do it, so careless conversions can create the very IRMAA problem you're trying to avoid.

Another tool is the Qualified Charitable Distribution, or QCD.

Once you reach age 70½, you can have money transferred directly from an eligible IRA to a qualifying charity. In 2026, the annual QCD limit is \$111,000 per individual. For someone who is subject to RMDs, a qualifying QCD can count toward that RMD while generally not being included in taxable income.

That distinction can be important because reducing taxable income can also help keep you below an IRMAA threshold.

And if your income drops because of a recognized life-changing event, Social Security allows you to request a reduction in your IRMAA using Form SSA-44. But don't assume that form will simply erase the consequences of a large voluntary home sale or other one-time taxable transaction. Its rules are more specific than that.

The Point of This Sidebar

I'm not a tax professional, and this isn't tax or legal advice.

It is a heads-up.

We tend to think of retirement as a simple equation: Social Security + pension + IRA + 401(k) + whatever is left in the bank.

But retirement income doesn't exist in isolation.

The tax code, Social Security, Medicare premiums, required distributions, investments and even the sale of your home can all interact.

And sometimes the biggest surprise isn't the tax bill when you sell the house.

It is the Medicare bill that arrives later.

So if you are approaching retirement, or already retired, and you are thinking about selling a home that has appreciated substantially, don't look only at the sale price and the capital-gains tax.

Look at what that sale does to your income.

Because your house may be your biggest piggy bank.

And Medicare may be standing nearby, waiting to see how much you put into it.