
A NATIONAL CONCEPTUAL FEASIBILITY STUDY

WHAT IF HEALTHCARE WORKED FOR EVERYONE?

Universal U.S. Healthcare | 2025-2054 scenario model

26

benefit areas

\$5.279T

2024 funding baseline

30

simulated years

THE VERDICT

GO

for serious policy development.

Not yet a verified savings case or a launch-ready financing plan.

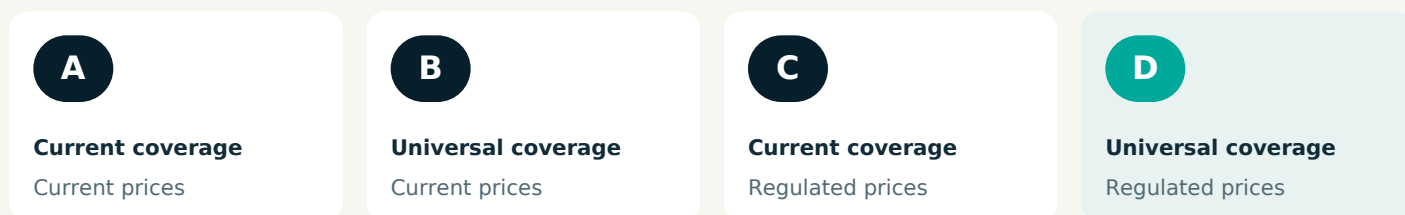
INDEPENDENT PROVIDERS / PUBLIC PAYER / REGULATED PRICES

THE DESIGN IS COHERENT.

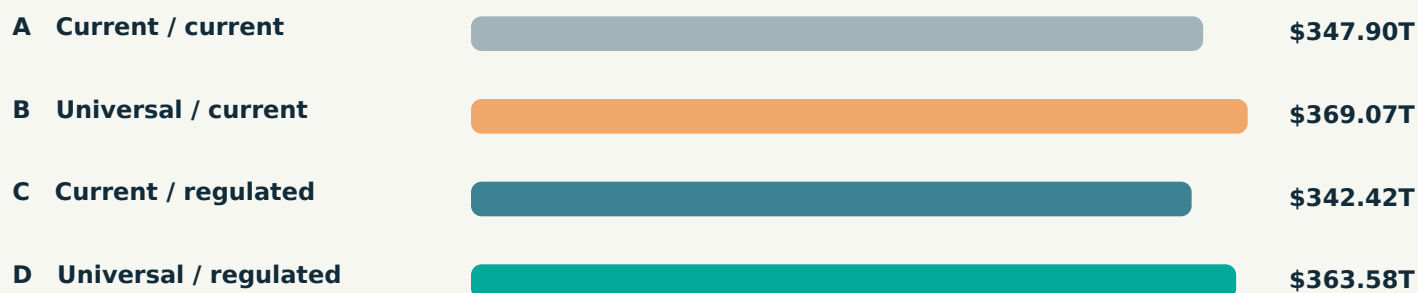
THE SAVINGS ARE UNPROVEN.

The question is not whether universal coverage costs nothing. It is whether broader care plus nationally regulated prices can deliver enough financial and human value to justify moving forward.

FOUR DISTINCT TESTS



30-YEAR SPENDING / LIMITED REPRICING



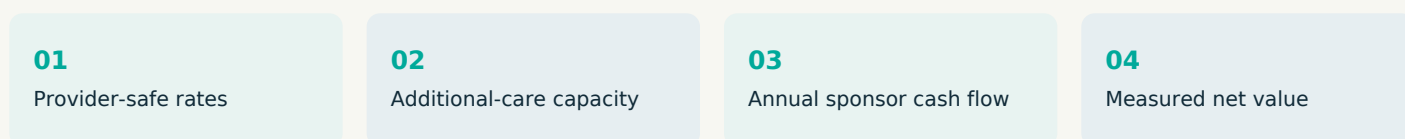
D - A = +\$15.68T | Assumed limited commercial-price changes only

THE LEVER THAT MATTERS: SERVICE PRICES

+\$2.31T TO **-\$4.07T**

Four constructed 30-year Medicare-reference price scenarios. The sign can change mathematically; no row demonstrates a nationally sustainable or verified savings outcome.

FOUR CONDITIONS GOVERN THE NEXT DECISION



Scope: Conceptual feasibility only. The detailed report preserves the financial ledger, scenario assumptions, source comparisons, limitations, and audit trail. No existing staffing problem is newly assigned as a cost of this proposal.

Decision: GO for the concept as a serious, testable policy option. NO-GO for an actual national launch on the evidence currently available. Universal comprehensive care financed through one primary public payer and nationally regulated service prices is conceptually feasible. But neither nationwide net cash savings, provider-safe prices, an adequate transition financing mechanism, nor a measured net health benefit has been proved. This concludes our conceptual study, not an implementation certification.

Accounting convention. Unless specified otherwise, dollars are *nominal U.S. dollars*; **T** means trillion and **B** billion. Results are model scenarios, **not forecasts**, confidence intervals, budget scores, or estimates of actual legislation. The 2025–2054 dates denote a hypothetical simulation, **not a rollout that occurred**. This document supersedes earlier provisional headlines where the newer analysis corrected them.

1. What we decided to test

The proposition was wider than insurance coverage alone: suppose U.S. residents had universal access to a broad, prevention-forward set of services; patients faced no point-of-service charge for covered necessary care; a single primary **public payer** paid predominantly **independent hospitals and clinicians**; and the payer set or negotiated transparent **service-specific reimbursement amounts** rather than accepting the existing fragmented commercial-price system. Could the nation afford it, and would it be worth doing over five, ten, twenty, and thirty years?

The design includes **26 benefit lines**: (1) prevention and screening; (2) vaccination; (3) primary and chronic care; (4) maternity and reproductive care; (5) pediatric and developmental care; (6) emergency care and transport; (7) specialty consultations; (8) laboratories; (9) imaging; (10) inpatient hospitalization; (11) outpatient procedures; (12) oncology; (13) renal replacement and dialysis; (14) prescription medication; (15) dental; (16) vision; (17) hearing; (18) mental and behavioral healthcare; (19) substance-use treatment; (20) rehabilitation; (21) durable medical equipment and assistive devices; (22) home health; (23) long-term and personal care; (24) post-acute skilled nursing; (25) hospice and palliative care; and (26) care navigation, casework, and social support.

The model represents this full breadth in the **proposed policy and aggregate expansion allowances**. It is **not** a completed unit-by-unit 26-benefit actuarial forecast; no such precision should be inferred from the aggregate spending totals.

We used four combined scenario comparisons to distinguish expanded care from price-setting. They are **not** a controlled factorial experiment: the assumptions for rollout and administrative credits also differ across rows, so no single A/B/C/D subtraction isolates a causal policy effect.

Scenario	Coverage arrangements	Payment rates	Comparison illustrated
A	Current pattern	Current-price trajectory	Existing-system reference
B	Universal	Current-price trajectory	Expanded care without repricing
C	Current pattern	Regulated-price scenario	Repricing without universalization
D	Universal	Regulated-price scenario	Full proposed combination

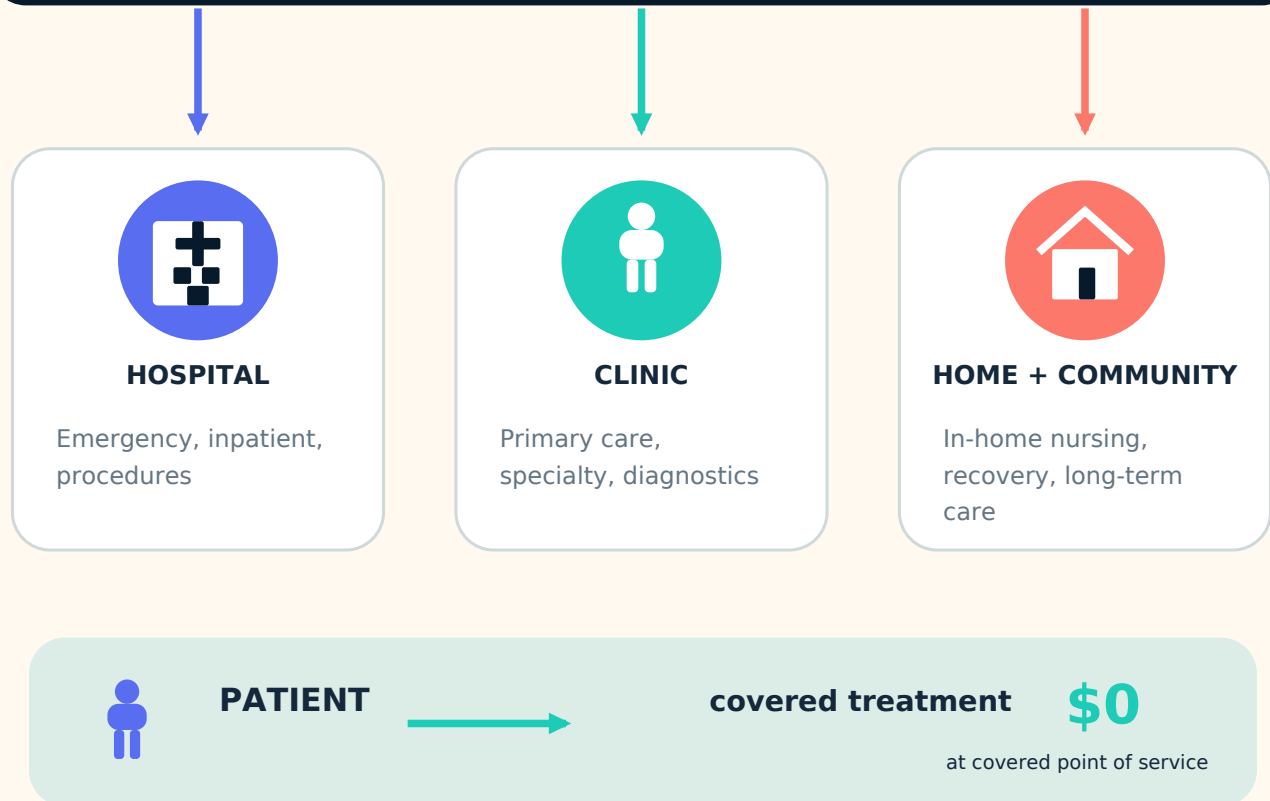
What was outside the assignment: solving today's hospital staffing shortage, designing every local clinic's operating plan, fixing unrelated preexisting system failures, or drafting a full tax code. Their existence is relevant to a potential launch; it does not create a newly invented cost in this conceptual national comparison.

One payer. A whole network of care.

A unified claims route changes payment administration; clinicians and facilities remain distinct.

PUBLIC FINANCING + CLAIMS

One payer, common covered-service rules



PARTICIPATION

Providers must accept the terms

STAFFED HOURS

Appointments are finite

LOCAL ACCESS

Distance still matters

A common insurance card does not create new operating rooms, staffed appointment hours or geographic access. A real provider-safe reimbursement model is required.

What does universal care actually include?

The full proposal spans 26 benefits, organized into six linked clinical journeys.



26 BENEFITS

30 TECHNICAL EVENT FAMILIES

Coverage is a promise to fund clinically appropriate services. Billing definitions, delivery pathways and real staffed capacity still require separate validation.

2. Baseline and assumptions: separate measurements from choices

Observed anchor. The official CMS 2024 National Health Expenditures total used throughout is **\$5.278588T**. CMS's ultimate-sponsor categories form the starting national financing account. Its payer-by-service matrix informs which spending can be plausibly repriced. These are accounting data, not evidence that the modeled changes will occur.

Assumed simulation mechanics:

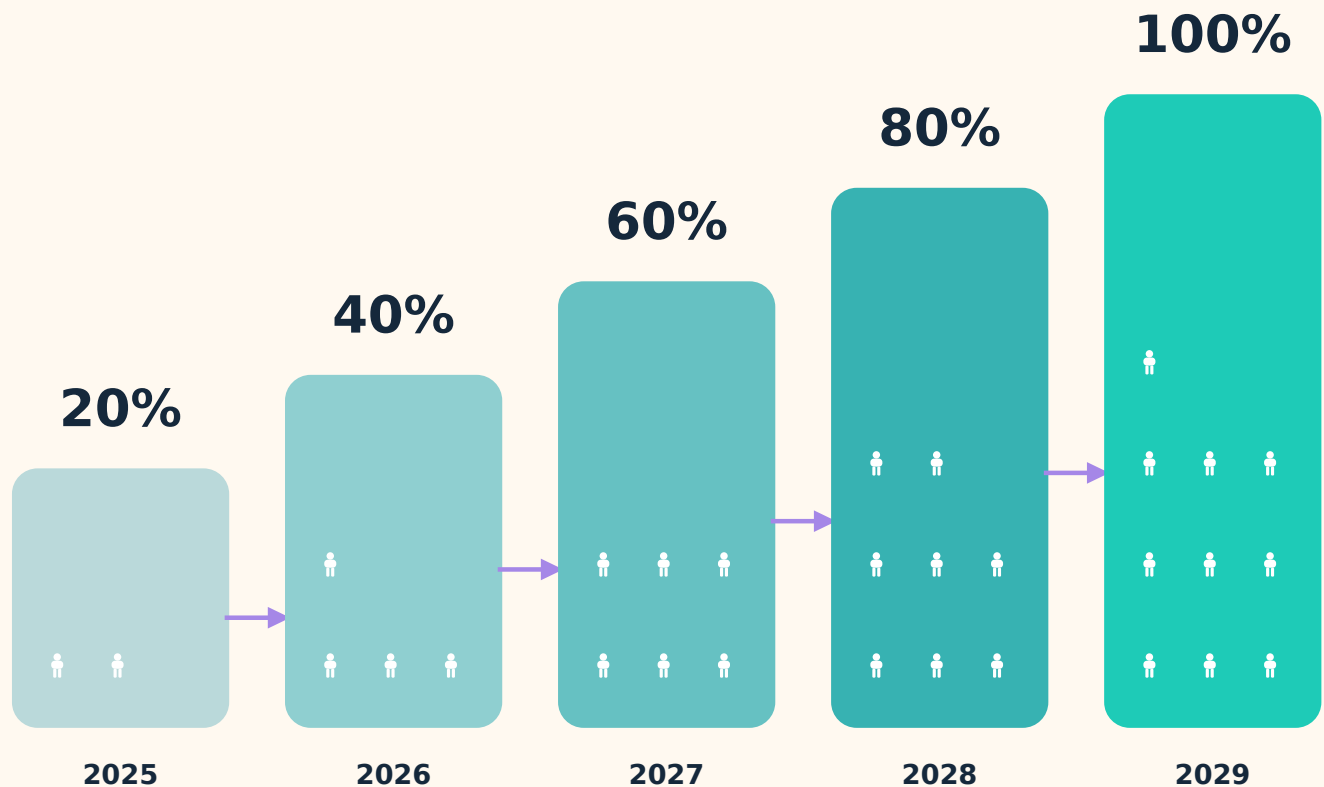
Input	Model choice	Status
Nominal status-quo growth	5.4% annually through 2034; 4.0% from 2035 to 2054	Assumption, not a CMS 30-year forecast
Universal transition	Hypothetical 20%, 40%, 60%, 80%, 100% progression, 2025–2029	Assumption, not historical activity
Additional ongoing treatment	6% recurring covered-care allowance	Assumption; higher care use has a real cost
Incremental facilities/workforce investment	1% allowance	Assumption for the expansion, <i>not</i> a price tag on preexisting staffing problems
Deferred-care demand	Initial wave, with catch-up delivery limited to 3% of baseline spending annually	National simulation cap, not verified staffed throughput
Administrative changes	Conditional net savings after replacement public administration	Not the gross disappearance of insurers' whole spending
Early detection savings	\$0 credited without national causal validation	Discipline against double counting

The reference A-case cumulative spending rises to **\$30.989T** over 5 years, **\$71.299T** over 10, **\$182.821T** over 20, and **\$347.901T** over 30. These nominal totals are driven heavily by the assumed spending-growth path. They are not present-value amounts.

Five years on paper. Three real-world gates.

Coverage phase-in is simulated; provider participation and financing must be demonstrated.

HYPOTHETICAL COVERAGE PHASE-IN



2029 | 100% COVERAGE IN THE MODEL



PAYMENT

Viable tariffs + claims systems



CAPACITY

Real staff + facility hours



FINANCE

Sponsor cash + transition reserves

The scheduled 2029 100% uptake is a spreadsheet input, not evidence of capacity, certified clinical readiness or an enacted funding mechanism.

3. A/B/C/D: the tested, limited-price middle case

The original revised *middle case* modestly reduces only identified commercial-payment pools: roughly **10%** on selected privately insured hospital payments, **5%** on selected professional/clinical payments, small additional category reductions, and a **40% net reduction** in private-insurer nonmedical expenditure after allowing for public replacement. These are hypothetical adjustments, **not** the full government-set-price concept.

Cumulative national health expenditures, trillions of nominal dollars

Years	A: current/current	B: universal/current	C: cur- rent/regulated	D: univer- sal/regulated	D – A
5	30.99	32.66	30.68	32.34	+1.35
10	71.30	76.46	70.33	75.49	+4.19
20	182.82	194.64	180.03	191.85	+9.03
30	347.90	369.07	342.42	363.58	+15.68

On the exact 30-year ledger, wider coverage and associated care increase nominal expenditure by **\$25.660T** compared with A before the tested adjustments. The limited commercial-service price changes then offset **\$5.484T**, and assumed net administration savings offset **\$4.495T**. The remaining **D – A = +\$15.681T**, or approximately **4.51%** of A-case cumulative spending. This is an increase in *all-sponsor national healthcare consumption/payment*, **not** an automatic federal deficit or the value of a new household tax.

Guarded, middle, and aggressive variants of these *limited* repricing assumptions produced **+\$22.023T**, **+\$15.681T**, and **+\$7.595T**, respectively, in 30-year D–A cost. The guarded-to-aggressive range is a set of **chosen assumptions**, **not** a probability interval and **not** a bound on what a comprehensive rate schedule could do.

Initial rollout illustration: middle-case D–A annual costs in the five simulated years 2025–2029 were **+\$0.078T**, **+\$0.165T**, **+\$0.261T**, **+\$0.366T**, and **+\$0.483T**. The modeled backlog peaks around **\$0.530T in 2030** and mathematically clears around **2036**, **only if** its assumed added treatment throughput is achieved. A national spending queue is not a patient count, local scheduling forecast, or demonstration that individual specialties have appointments available.

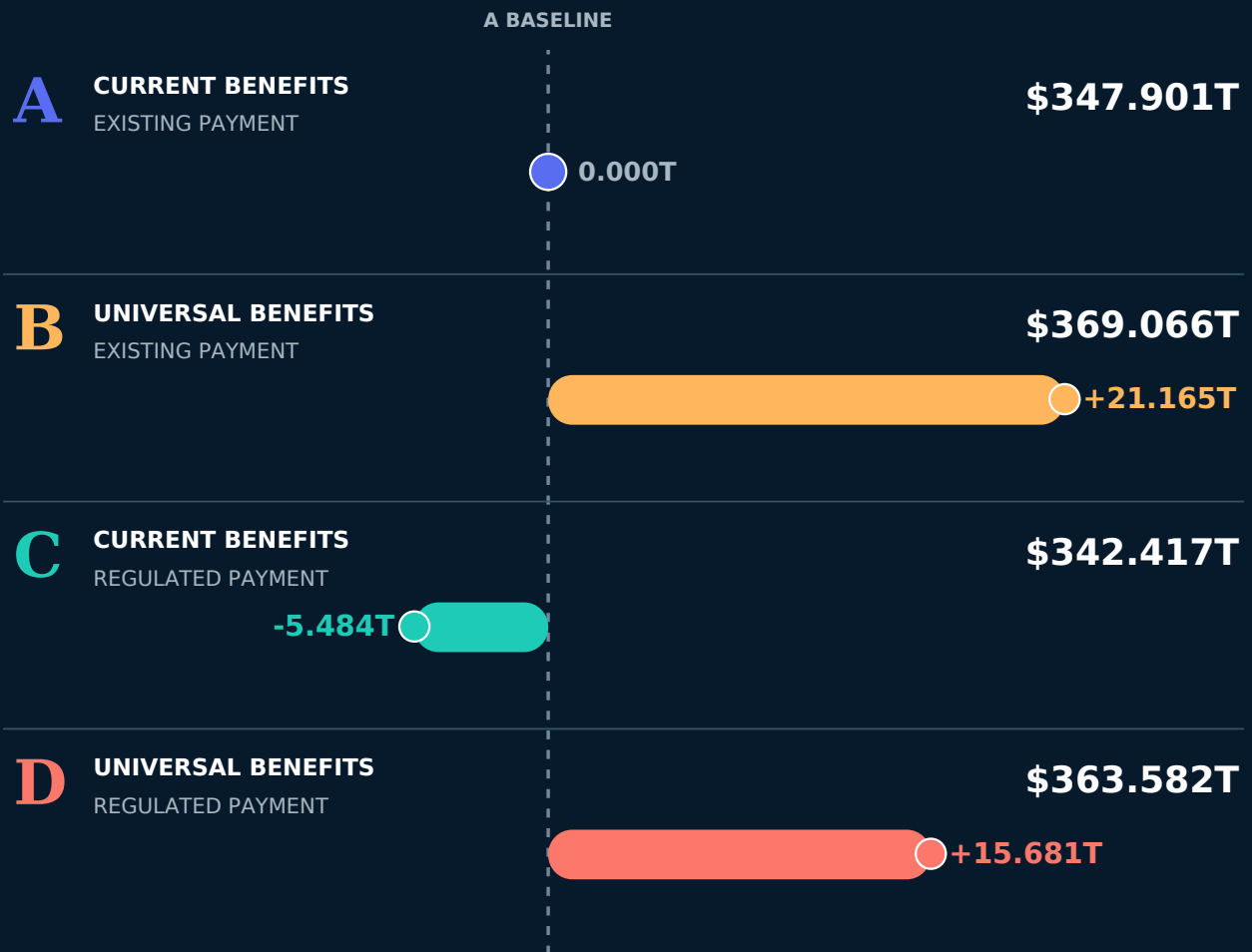
Same population. Four spending assumptions.

Each case changes covered services, payment rules or administrative savings.

30-YEAR NATIONAL EXPENDITURE / NOMINAL \$T

SIGNED DIFFERENCE VS A

TOTAL SPEND



D - A +\$15.681T

Conditional full-scenario difference; not a measured causal effect

4.51% ABOVE A

B includes a conditional administration reduction; C shares D's rollout multiplier for repricing. A-to-D is the comparison of whole assumptions, not a controlled causal effect.

How much does universal care cost?

A 30-year national spending equation, not a federal borrowing estimate.

\$363.582
TRILLION

SCENARIO D / SELECTED MIDDLE CASE

+\$15.681T

More covered care costs more than the two conditional efficiency credits save.



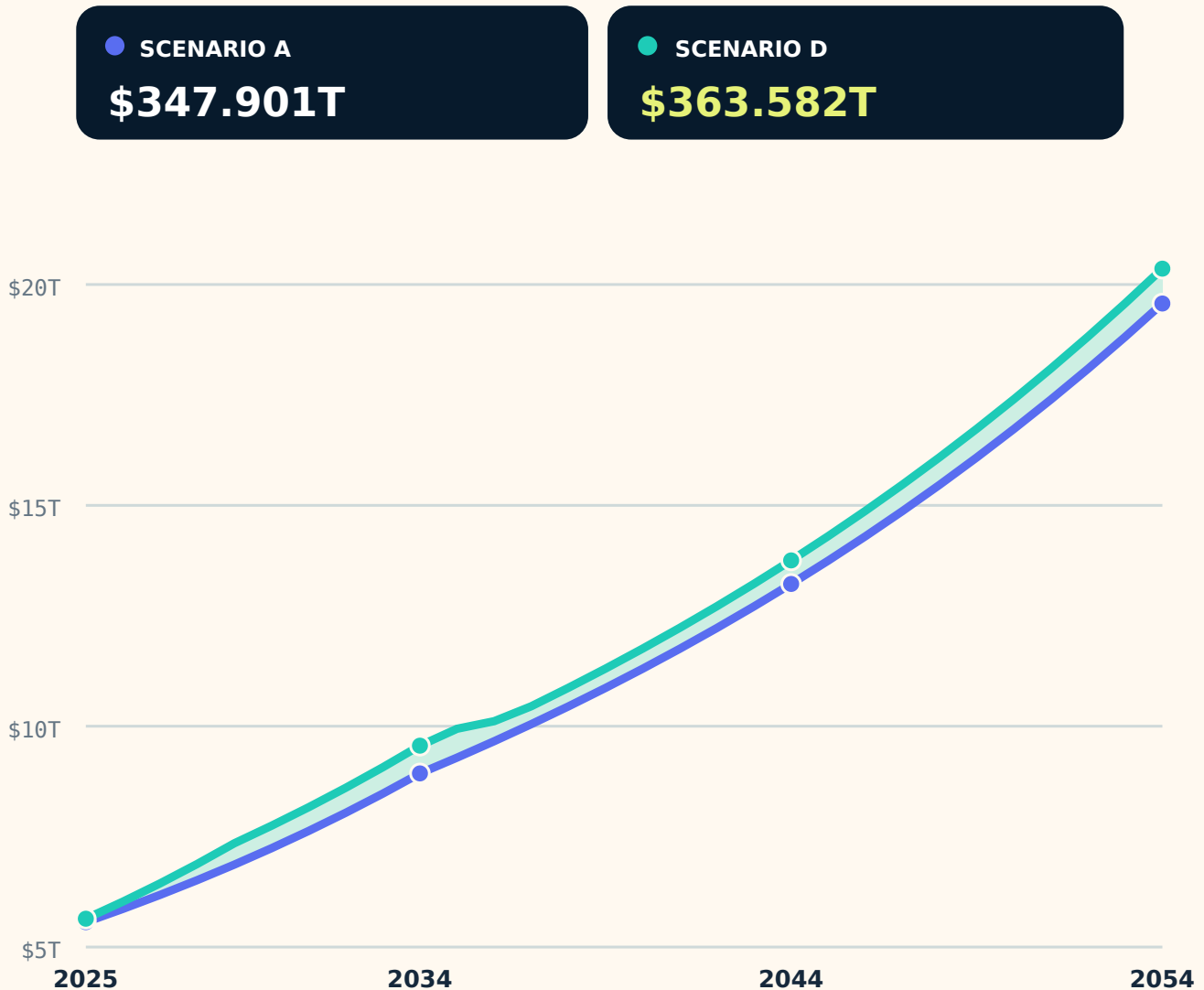
$$347.901 + 25.660 - 5.484 - 4.495 = 363.582$$

ALL FIGURES NOMINAL \$T | APPENDIX C CENTRAL SCENARIO

Additional care +\$25.660T, minus repricing \$5.484T and conditional administration \$4.495T. Total recorded national healthcare expenditure rises \$15.681T.

Two spending paths diverge over time.

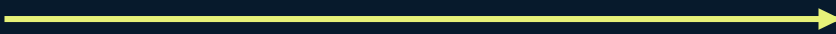
The 2025–2054 Appendix C ledger charts national nominal payments under A and D.



This accounting forecast is not independent proof of real labor and supply costs, a federal appropriation, or an achievable clinical throughput plan.

Catch-up demand arrives before capacity is proven.

The modeled \$0.530T queue is deferred expenditure, not patients or booked appointments.

2025  ~2036

~\$0.530

TRILLION DEFERRED SPENDING

SIMULATED PEAK 2030

6%

ONGOING NEW CARE

1%

CAPACITY INVESTMENT

3%

BASELINE SPEND/YR CEILING

The queue clears only under assumed throughput and staffing. Its dollar profile does not tell us how many people can obtain clinically necessary care.

4. Correcting the critical under-test: comprehensive regulated prices

We subsequently realized that a 10%/5% commercial-fee adjustment **did not seriously test the central proposed lever**: nationally determined, service-specific reimbursements. We therefore tested additional *Medicare-reference* illustrations rather than treating the middle-case \$15.681T gap as the final answer.

Each illustration below uses **135% of Medicare for applicable hospital payments, 100% of Medicare for applicable professional payments**, and an illustrative **\$25B per 2024-equivalent year in hospital viability support**, while retaining the **6% added-care assumption** and the existing net-administration treatment. The private-to-Medicare reference ratios and outpatient-mix information differ by source. Because these are **cross-dataset constructed examples**, the same nominal proposed rate schedule does **not** imply the same reduction to aggregate national spending in all rows.

Illustrative D – A cumulative differences, trillions of nominal dollars

Price evidence / mix	5 years	10 years	20 years	30 years
JAMA (29% outpatient)	+0.588	+1.819	+2.222	+2.311
Milliman + RAND (51% outpatient)	+0.352	+1.088	+0.123	–1.814
Milliman + HCCI (62% outpatient)	+0.321	+0.993	–0.149	–2.348
RAND + Milliman (matched 2.583× hospital ratio)	+0.223	+0.689	–1.024	–4.066

Interpretation: Price policy is powerful enough in the *arithmetic* to change the 30-year sign. In all four illustrations the early five- and ten-year rollout still costs extra, reflecting increased necessary treatment before later savings accumulate. The 20- and 30-year direction varies depending on the reference dataset and payment composition. **None of the negative figures establishes net savings that are nationally achievable, legally enacted, or safe for providers.** Nor are these four rows statistical lower and upper bounds, and they must never be averaged into a forecast.

The underlying source concepts explain why we cannot make that leap:

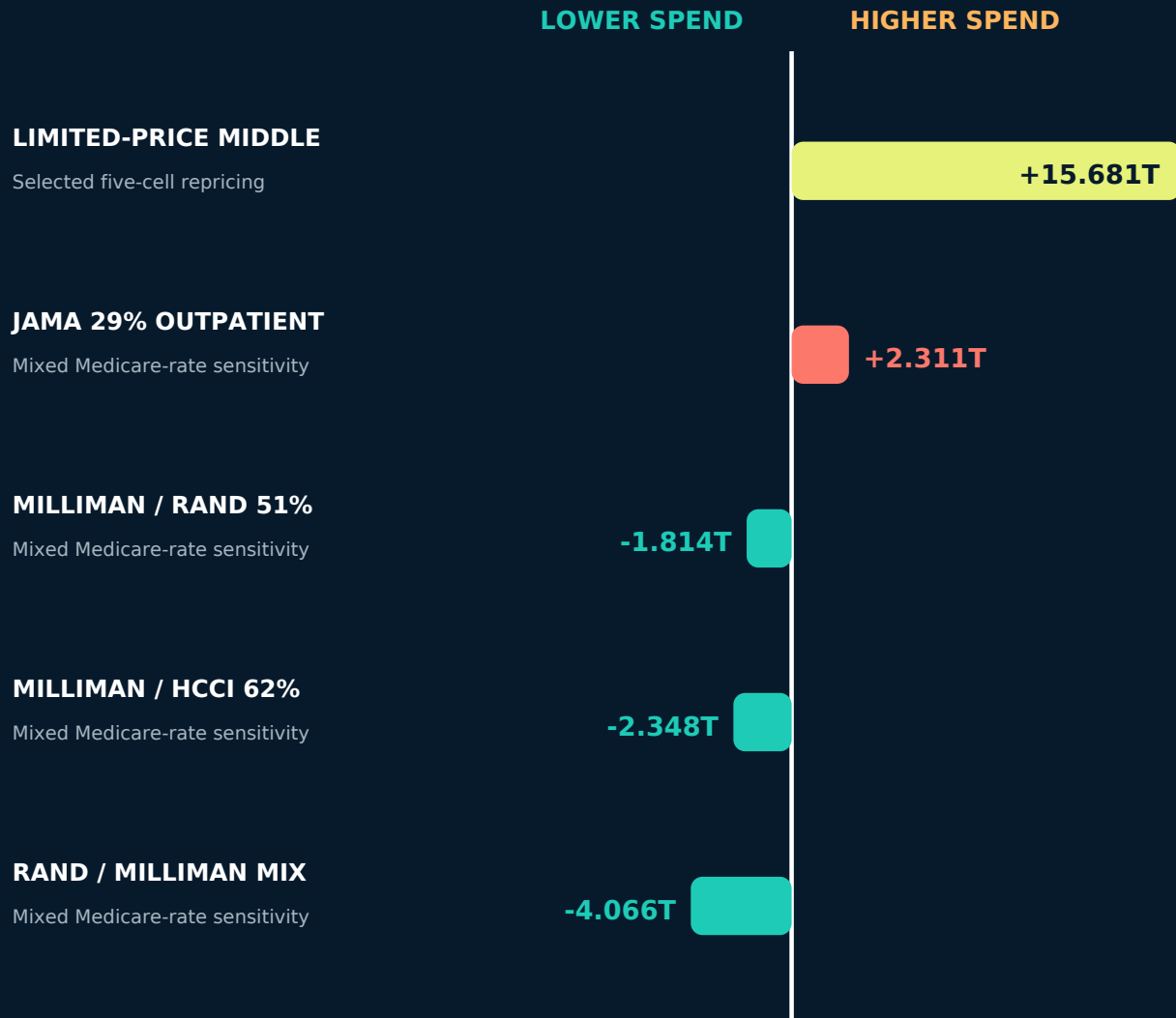
- **RAND:** Its matched commercial facility claims produced about **\$71.3B** in private payments and **\$27.6B** when repriced at Medicare, a sample combined **2.583×** ratio. The sample's roughly **51% outpatient share** is *not* CMS's national all-hospital outpatient share.
- **HCCI:** Its employer-sponsored insurance outpatient facility expenditures of about **\$1,889 per person** versus **\$1,154 inpatient** imply an approximately **62% outpatient share** *for that population and measure*, not all national hospitals.
- **Milliman:** Its **published national 2024 ratios** are **2.05×** inpatient, **2.63×** outpatient, **1.43×** professional. The historical examples above instead used **2.06×** / **2.60×** / **1.42×**. Their reported results are preserved for traceability, **not** certified as source-aligned national tariffs (Document 4, Appendix F).
- **JAMA:** Studied approximately **1.89×** inpatient, **3.83×** outpatient, and **1.24×** physician, with a **71/29 inpatient/outpatient mix in its sample**. A study's blended hospital ratio cannot simply be used to divide the entire CMS hospital spending total.

We explicitly **withdraw** the prior approximately **+\$0.155T/30-year “near break-even”** illustration generated by applying an unsuitable blended hospital payment ratio to the national denominator. It was not a justified national bridge. The corrected service-mix examples above replace it *as sensitivities*, not forecasts.

Provider-side limit. MedPAC reported a **–12.1% Medicare fee-for-service hospital margin** for fiscal 2024; Medicare-reference rates therefore do **not** establish a nationally sustainable facility budget. Our cross-source hospital-cost screens are **proxies**, not verified same-service delivery-cost or provider-viability audits. The **\$25B hospital support** term is assumed, not validated for rural, safety-net, teaching, high-acuity, or specialty care. No provider-safe national schedule is certified. The practice-survival graphic uses **hypothetical costs and rates**, not observed practice data; the price constraints remain future launch gates, not an instruction to reopen local research in this closed conceptual study.

Modeled price changes matter.

Mixed-source Medicare price illustrations; no validated national savings.



ILLUSTRATIVE RATE COMPARISONS - NOT VERIFIED NATIONAL SAVINGS

The four deep-price cases mix different source populations, assumed provider support and reported-versus-recomputed residuals. No case verifies a safe national tariff.

Provider survival needs cost-matched evidence.

At a hypothetical 135% of observed Medicare payment, inpatient costs remain uncertain.

2,882

IPPS HOSPITALS

145,586

PUBLISHED DRG ROWS

4.945M

SAMPLED DISCHARGES

6.41%

ESTIMATED PROXY-UNDER-COST DISCHARGE EXPOSURE



93.59% not flagged by this proxy

Not an observed national loss rate

\$1.240B

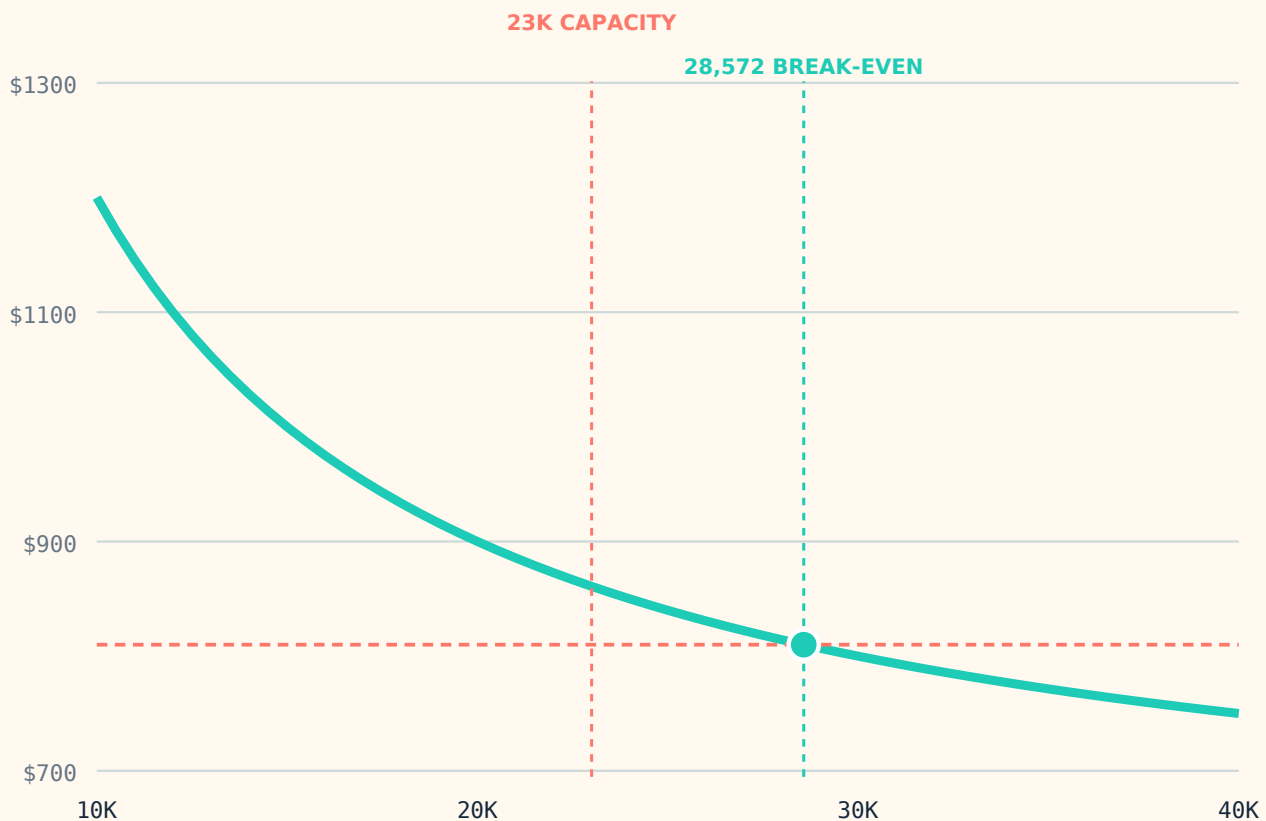
SELECTED-DRG PROXY SHORTFALL

Not a measured universal provider-support requirement

The proxy joins 2023 hospital cost-to-charge ratios to published 2024 inpatient DRG claims. It excludes other service lines and does not certify safe national payment rates.

Ten percent less can mean 43% more cases.

An illustrative practice: \$6M fixed costs, \$600 variable costs per case.

\$900**OLD PAYMENT****\$810****NEW PAYMENT****\$210****NEW CONTRIBUTION****MAXIMUM 23,000 CASES****-\$1.17M OPERATING RESULT**

SOURCE: REQUIRED RATE = \$600 + \$6M ÷ ANNUAL CASES

The 28,572-case break-even exceeds staffed capacity in this illustration. The example is a stress test, not an observed national payment rate or a closure forecast.

5. Financing: existing money moves; new expenditure must be funded

The payer who processes a claim and the *ultimate sponsor* who contributes the money are different. One public payer does **not** mean every healthcare dollar must originate in the federal budget, nor that premiums can simply vanish without replacement resources.

CMS-observed 2024 ultimate sponsors, billions of dollars:

Ultimate sponsor	2024 amount
Federal government	\$1,652.0B
State and local governments	\$859.7B
Households	\$1,458.9B
Private businesses	\$967.4B
Other private revenues	\$340.5B
Rounded source-cell sum	\$5,278.5B

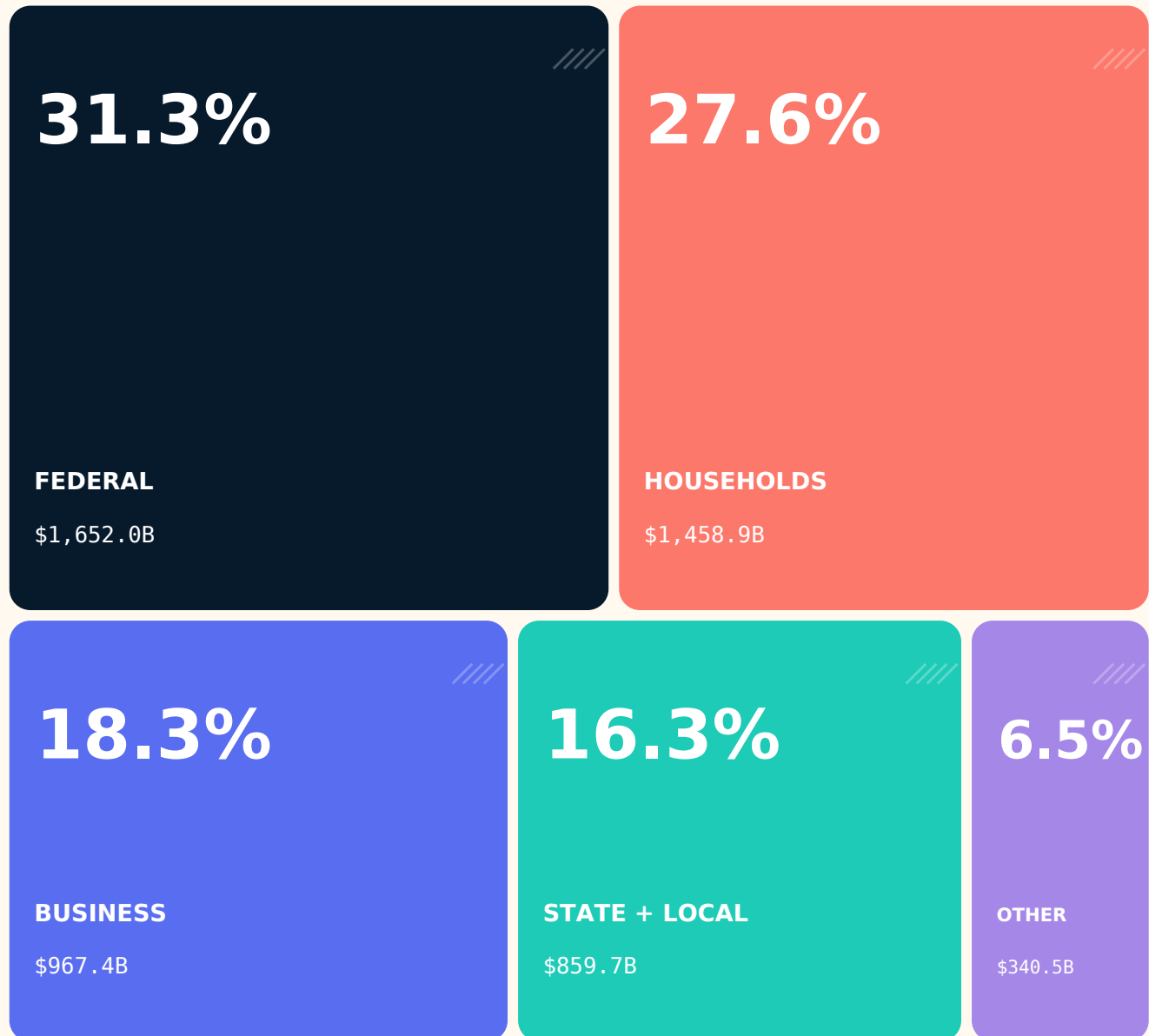
The \$0.1B difference from the national **\$5,278.6B** reported total is normal published-cell rounding. The approximately **\$556.6B** in 2024 out-of-pocket expenditure is part of current financing/spending already reflected in the accounts: **do not add it again** as a separate resource pool. Under the proposed system, covered care would have **\$0 point-of-service charges**; replacement household and business contributions would have to be explicitly designed, not hidden as copays.

The conditional *limited-price middle first five-year* identity illustrates scale: **\$32.342T total D spending** is approximately composed of **\$19.245T of existing sponsor resources redirected into the primary public payer + \$1.353T of incremental financing + \$11.745T of remaining source expenditures**. Because the displayed components are independently rounded to \$0.001T, they sum to **\$32.343T**, or **\$0.001T above** the displayed total. This is an illustrative transfer ledger based on that scenario, **not the allocation for any of the deeper tariff examples**. Redirected premiums, taxes, state payments, and existing public program expenditure are **not all new taxes**. A government-versus-private-share comparison that simply moves claims between columns must not be mistaken for trillions of extra medical resources.

We explored hypothetical federal/household/employer funding allocations, payroll and personal-income bases, and how average premiums differ by household and employer size. Those checks show that *distributional decisions are real*, but do **not** establish an enacted replacement levy, actual net household winners and losers, a federal borrowing requirement, or a budget-neutral transition. The complete yearly transition cash flow has **not** been established.

The healthcare dollar has five sponsors.

CMS 2024 measured national expenditure: \$5.278588 trillion across ultimate sponsors.

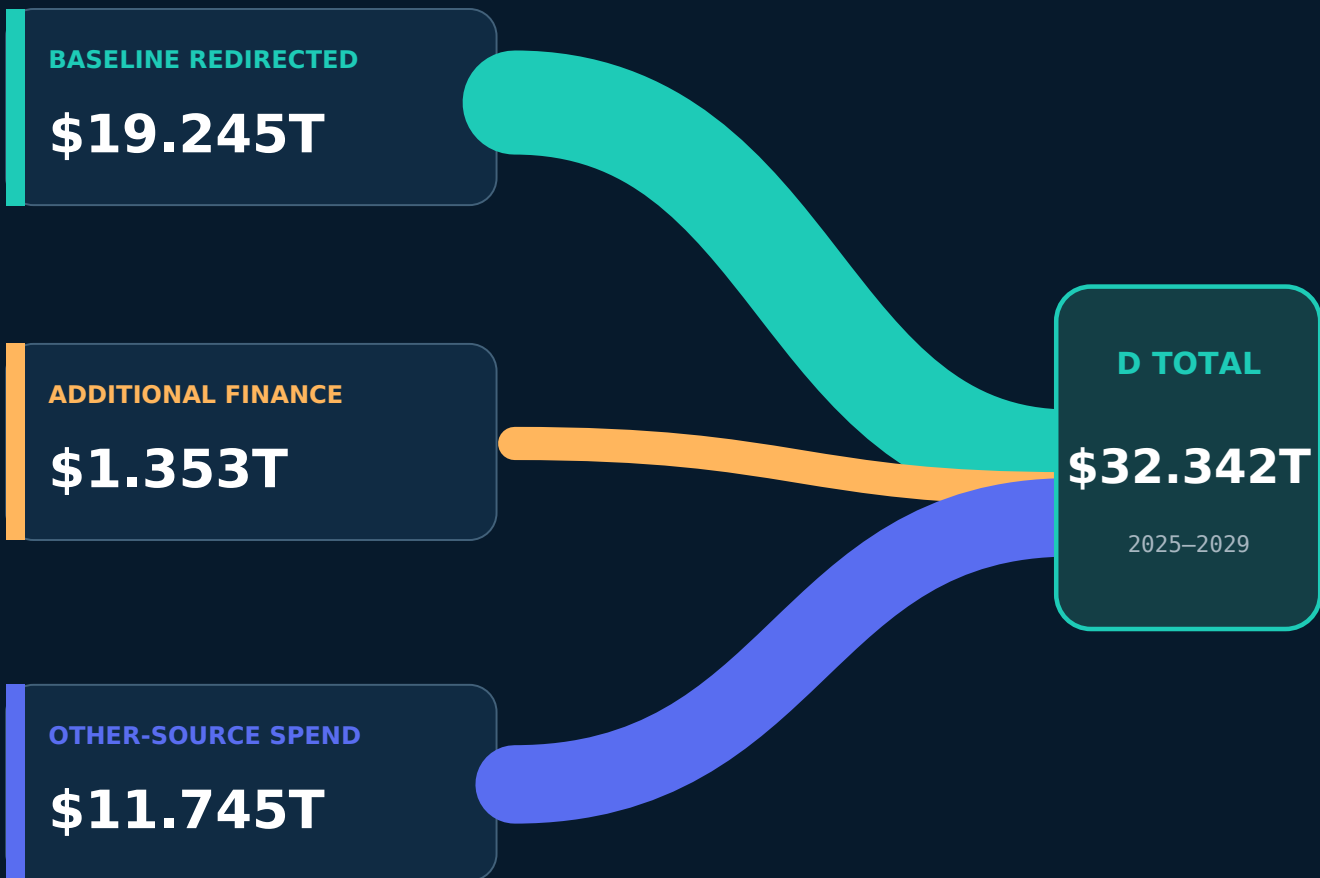


SHARES DESCRIBE WHO ULTIMATELY PAYS — NOT FIVE EXTRA COSTS

Tile areas approximately reflect the five reported shares; rounded dollar cells total \$5,278.5B. Sponsorship and provider-payment categories cannot be added twice.

Re-route the funds; don't count them twice.

Five-year Scenario D funding channels represent the same \$32.342T national cost.



THREE FUNDING CHANNELS, ONE \$32.342T TOTAL

DISPLAYED CHANNELS ARE INDEPENDENTLY ROUNDED

These are funding allocations within the D total, not extra costs to add to it. The \$0.001T visible discrepancy is rounding of component displays.

6. The health side: earlier detection, more treatment, and long horizons

Our case for evaluating universal care is not confined to a lower national hospital bill. The proposition intentionally shifts money and activity toward *care that people currently miss or delay*. That can improve quality and length of life and financial security even if certain people use more services for longer.

The study's service-activity register separates **covered services and eligibility** from **completed clinical care**. A modeled place in a service pathway must not be counted as a delivered appointment or proven additional capacity.

The 2025 U.S. Census resident population figure used for screening cohorts is **341,784,857**. Our illustrative targets demonstrate the difference between an eligible population, newly up-to-date participants, tests performed, and available appointment slots:

Illustration	Cohort / baseline	Hypothetical improvement	Interpretation
Colorectal screening, ages 45–75	120.894M people; 67.4% baseline up-to-date (2023 survey assumption carried to the sized cohort)	+ 12.09M or +24.18M people current at +10 or +20 percentage points	<i>People current</i> , not 12–24M annual colonoscopies; FIT requires diagnostic follow-up when positive
Breast screening, females 40–74	72.498M age-cohort estimate	+ 7.25M–11.95M people newly current in tested scenarios	Not an unduplicated patient count when combined with other screenings
Mammography workload in simulation year 5	FDA approximately 45.08M annual national procedures as scale comparator	+ 4.35M–7.17M procedures including repeats	Equivalent to 9.65%–15.91% of comparator volume; <i>not</i> proof of available appointment capacity

The cohorts overlap and must **never be summed as unique people**. Screening has follow-up, false-positive, overdiagnosis, treatment, and adverse-effect implications. Similarly, clinical-trial improvements for particular high-risk groups do not justify extrapolating the same benefit to 342 million Americans.

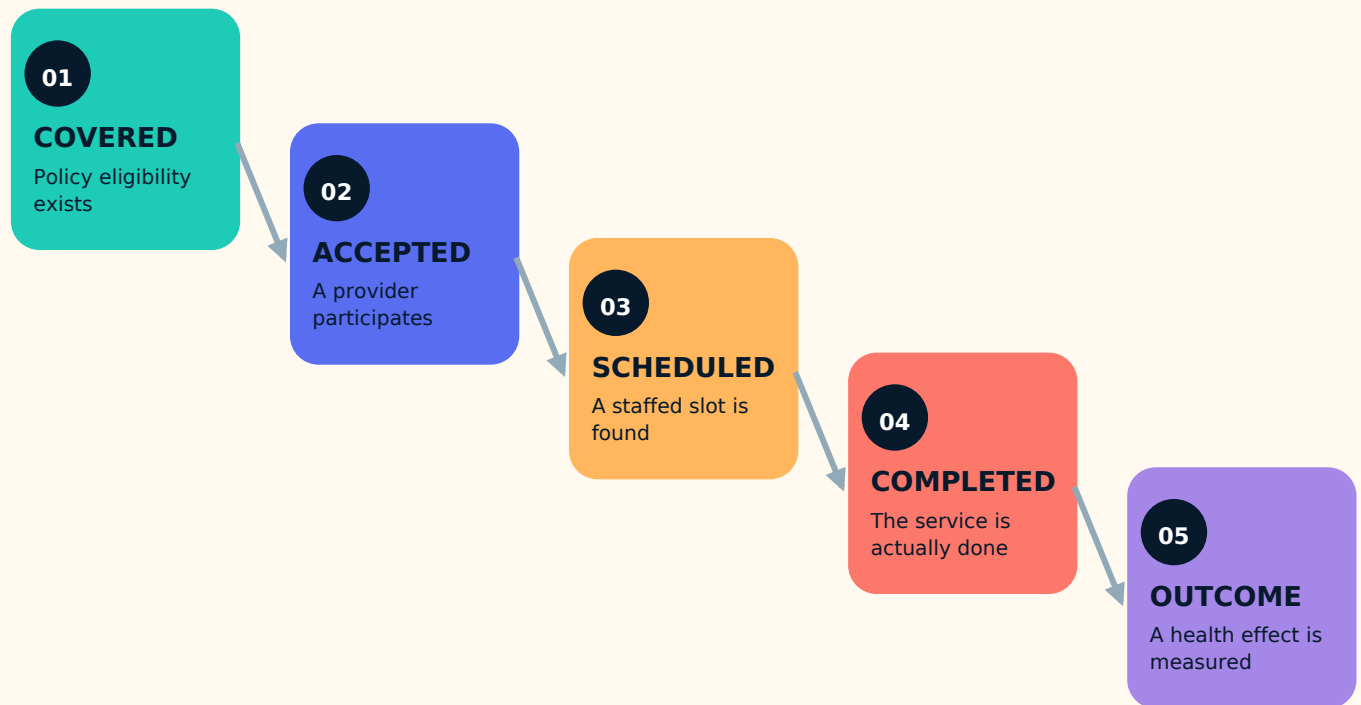
We tracked benefits by time horizon: years **1–5** emphasize access, diagnostics and backlog treatment; years **6–10** capture follow-through and initial chronic-disease trajectories; years **11–20** incorporate aging of earlier-treated cohorts, disability and complications; years **21–30** include lifetime care, healthy years and financial protection. Living longer can increase lifetime treatment spending even while generating highly valuable healthy time. For that reason the model credits **no undocumented nationwide clinical cash offset**; it also **does not presume the human benefit is zero**.

A bounded health-value check—not a claim of lives saved

For the **limited-price middle case only**, its **+\$15.681T nominal** cumulative difference was translated under an assumed **2% inflation and 3% real discount rate** into an approximately **\$7.551T 2025 present-value gap**. The comparable 30-year annualized real value is about **\$374B annually**. At willingness-to-pay yardsticks of **\$100,000** or **\$150,000 per quality-adjusted life-year (QALY)**, respectively, this corresponds to **3.74M** or **2.49M incremental net QALYs per year** across the population needed to justify the modeled extra real resource cost, *if* the valuation framework were accepted. These are **thresholds**, not measured clinical outcomes or death counts; avoided financial hardship and work/caregiving effects may add value but cannot be booked without evidence. **Do not transfer this threshold to the stronger price scenarios**, which have different expenditure gaps.

Coverage is only the first step toward care.

A person can hold a benefit without finding a staffed clinical appointment.



3,600

SCENARIO x YEAR x EVENT-FAMILY POSITIONS

REQUESTS

UNMEASURED

STAFFED HOURS

UNMEASURED

COMPLETIONS

UNMEASURED

3,600 SCENARIO POSITIONS

0 VERIFIED FUTURE SERVICE COUNTS

The Step 107 register defines data positions, not patient records. National requested events, staffed capacity and completed care remain unmeasured.

A screening test is the beginning of a care path.

Colorectal and breast-screening demand must connect to diagnostic follow-through.

COLORECTAL CATCH-UP / ANNUAL

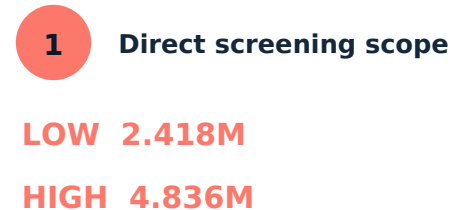
LOW 2.418M

HIGH 4.836M

FIT-FIRST



DIRECT COLONOSCOPY



This is an alternative strategy, not an add-on to every FIT test.

BREAST SCREENING - YEAR-FIVE ADDED WORKLOAD

LOW 4.350M

HIGH 7.171M

45.084M OBSERVED ANNUAL TOTAL MAMMOGRAMS = USE, NOT UNUSED CAPACITY

Low and high are alternative modeled demand scenarios, not ratios. Screening tests, diagnosis and treatment are separate clinical workloads.

How much health benefit would justify the cost?

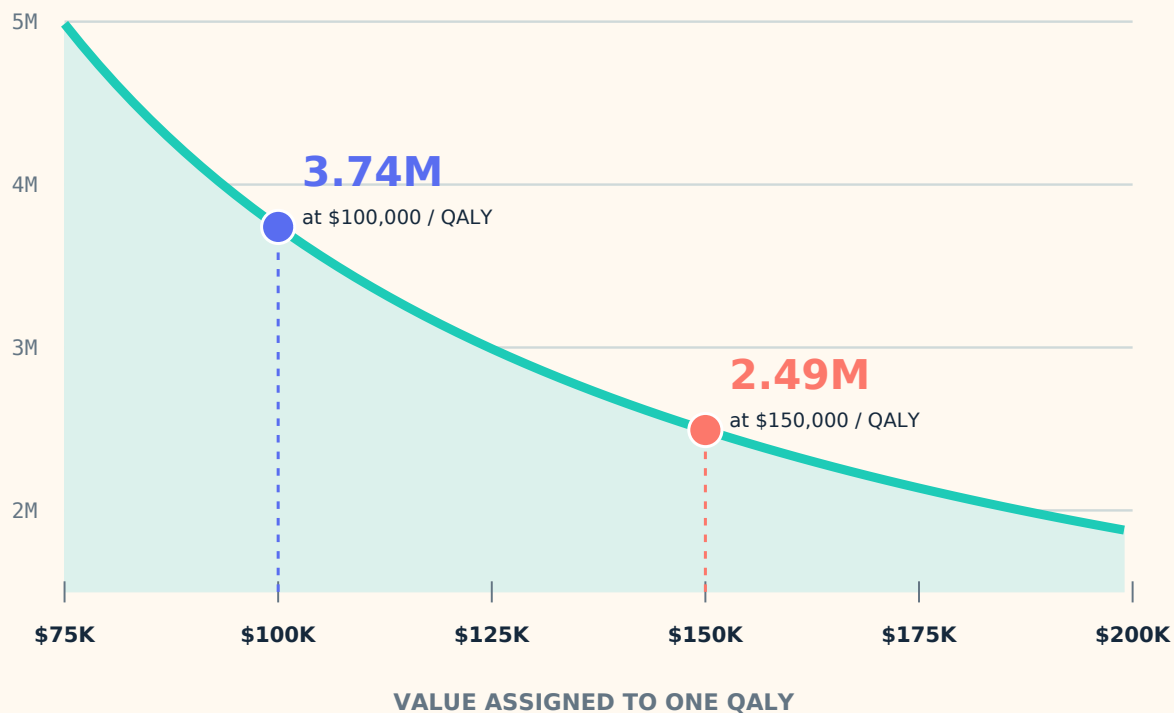
The limited-price middle model supplies a value threshold, not proven health gains.

\$374B

ILLUSTRATIVE EQUIVALENT ANNUAL COST

\$7.551T IN 2025 PRESENT VALUE

ANNUAL QALYs REQUIRED TO OFFSET THE MODELED COST



HEALTH IMPROVEMENTS ARE A REQUIREMENT, NOT A MEASURED RESULT

Earlier diagnosis, reduced medical debt and disability avoided still require outcome evidence.

These QALY thresholds depend on the selected \$15.681T nominal model gap, discounting and illustrative values per QALY. No achieved national QALYs were measured.

7. Savings discipline: do not turn a problem into a free credit

The study considered private insurance overhead, price dispersion, purchasing leverage, inappropriate charges, fraud/abuse, debt, uncompensated care, and avoidable late treatment. Only explicitly modeled, *nonoverlapping* price and conditional net administrative changes were allowed to reduce the spending ledger. In particular:

- **Fraud and improper payments:** A quoted **\$86.52B** FY2024 gross program improper-payment measure is **not a measure of proven fraud**, nor money automatically recoverable under a new system. The validated additional recoverable national dollar offset in our model remains **\$0**.
- **Hospital write-offs and bad debt:** Face values are **not** additional national costs saved and cannot be equated to tax refunds. Publicly paying a previously unpaid claim can stabilize a provider but remains a payment.
- **Medical debt stock:** A stock estimate (e.g., **\$220B** in earlier background material) cannot be applied as a recurring yearly cash saving.
- **Prescription/drug savings:** Purchasing changes are plausible, but extra whole-system discounts were **not** stacked on category cuts already modeled.
- **Screening and prevention:** Benefits are potentially substantial but do not qualify as a national expenditure offset before accounting for the screening itself, positive follow-up, care delivered, complications avoided and longer lifetimes.
- **Administration:** The limited case used a hypothetical **net** rather than gross private-insurer nonmedical reduction and should not be double-counted as savings against multiple payer accounts.

This conservative ledger is deliberate: *zero credited without support* is not the assertion that the real-world opportunity is zero.

The administration visual isolates the **conditional net** insurer-overhead offset already used in the limited-price case; it is not a second, additive saving. Likewise, the improper-payment visual distinguishes detected or estimated payment errors from demonstrated recoverable fraud.

Administration does not disappear.

A modeled 40% NET credit assumes the replacement system still costs money.

INSURER NONMEDICAL POOL / 2024

\$176.458B

40% ASSUMED NET SAVINGS

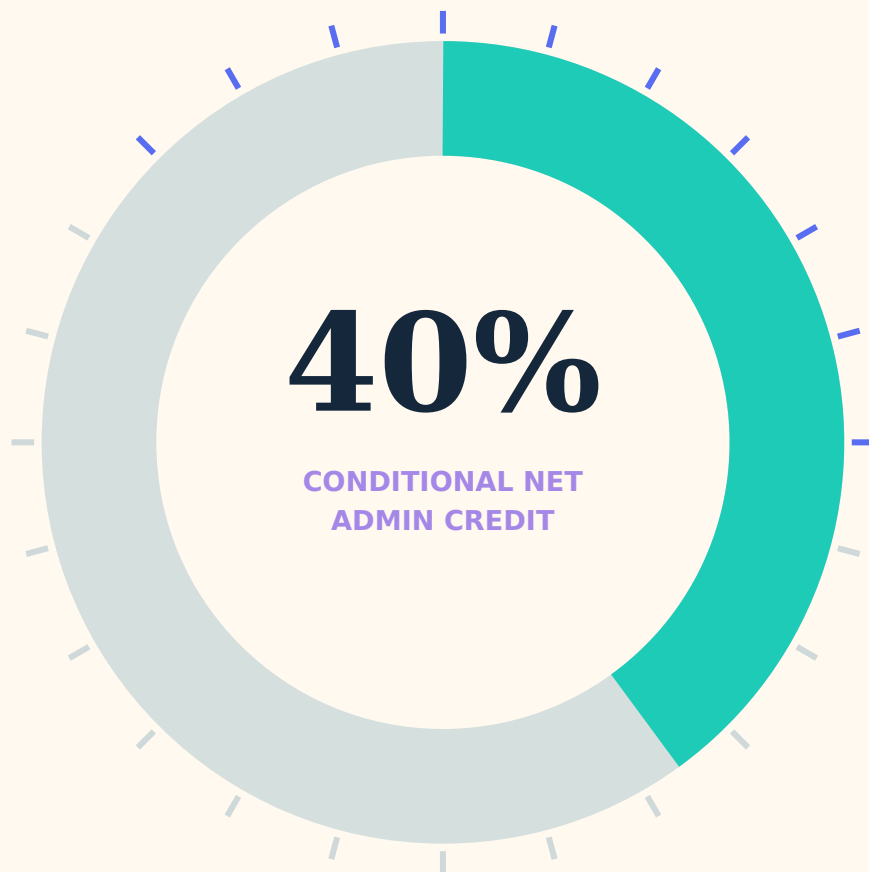
\$70.583B

Illustrative 2024-equivalent

FULL 2025-2054 MODEL

\$4.495T

Conditional cumulative credit already deducted inside Scenario D



60% OF THE 2024 BASE IS NOT CREDITED AS SAVINGS

Real public claims, technology, compliance and transition expenses still need costing.

This conditional credit is already included in the \$363.582T Scenario D total. Public claims processing, oversight, technology, migration and staffing still exist.

Improper payments are not a savings forecast.

Detection data must be separated from recoverable fraud and future program savings.

GAO / FY2023

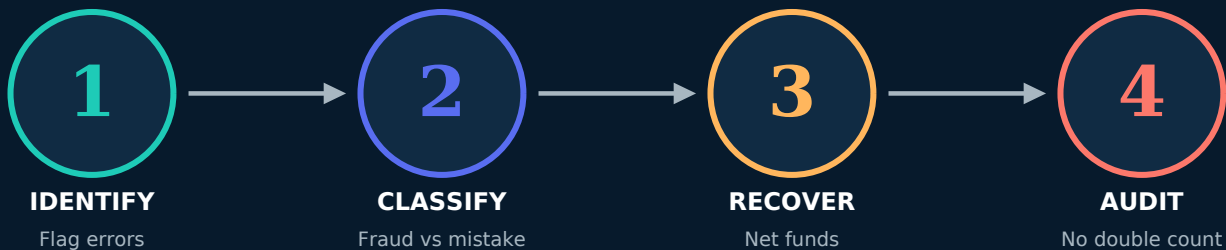
>\$100B

Medicare + Medicaid estimated
improper payments

CMS / FY2024

\$207M

Fraud Prevention System edit result



\$0

ADDITIONAL UNVERIFIED FRAUD SAVINGS

ENTERED INTO THE CENTRAL EXPENDITURE MODEL

Improper-payment statistics include documentation and other errors. No newly generated fraud savings can be booked without a distinct recoverable-cash estimate.

8. What the results establish—and what they do not

Question	Current national-study answer	Boundary
Can the design be described coherently?	Yes: 26 lines, universal coverage, independent delivery, one primary payer, service-specific prices, no covered point-of-care copays	Conceptual possibility, not statutory authorization
Will universalization initially increase treated demand?	Yes in the scenario: higher service use and early costs are explicitly modeled	Magnitude and actual local throughput are assumptions
Is the limited-price model cheaper?	No: D costs +\$15.681T/30yr versus A in its conditional middle case	This is <i>not</i> the proposed comprehensive-pricing ceiling
Could stronger government-set prices reverse spending direction?	Mathematically yes: constructed 30-year D–A sensitivities range from +\$2.311T to –\$4.066T	Not a provider-safe savings range or statistical interval
Is the payment system financially transitioned?	No: existing sponsor pools and sample reallocations have been reconciled	No enactable annual contribution and transition budget score
Do earlier diagnosis and coverage produce enough national net value?	Plausible, unmeasured at required population scale	No estimated national QALYs, causal lives saved, or certified cash savings
Must this study now fix existing staffing shortages?	No. Preexisting shortages are in the present system	Incremental rollout throughput remains a <i>later validation condition</i> , not another research workstream now

Four later go/no-go validation conditions, if the proposal advances beyond this finished conceptual study:

1. **Provider-safe tariffs:** representative, comparable-service *actual* operating costs and viable geographic, specialty, teaching, safety-net and acuity adjustments; avoid assumed unsustainable cuts.
2. **Incremental treatment throughput:** capacity for the proposed additional appointments and procedures, assessed against the *existing baseline*, including rural and specialty wait times. This does **not** require solving all current staffing issues first.
3. **Annual financing and transition ledger:** redirect current federal, state, employer and household sponsorship **once**, allocate additional resources and reserve/transition costs, and estimate distributional consequences.
4. **Net health and financial value:** nationally plausible outcomes, avoided disability, quality of life and household financial protection, alongside *separately demonstrated* healthcare cash savings or increases.

These are implementation-decision tests, **not tasks we are continuing inside this closed conceptual exercise**. The full national feasibility picture can be stated without exploring each hospital, city, tax bracket or clinical procedure further today.

The readiness graphic organizes the decision sequence into three checkpoints; the four **evidence conditions** listed above remain the actual substantive tests, not four newly completed certifications.

The county workforce display is intentionally narrow: a reported **zero in a particular workforce field** is not evidence that a county has no clinicians, no access, or a measured capacity shortfall under this proposal.

Coverage is not the same as delivery readiness.

Three implementation tests remain independent of the hypothetical 2029 phase-in.



THE THREE IMPLEMENTATION CHECKS ARE STILL OPEN



PAYMENT

Viable provider reimbursement

Claims, hospitals and specialty tariffs

UNVALIDATED



CAPACITY

Genuinely staffed appointments

Regional hours, waits and referral follow-up

UNVALIDATED



FUNDING

Reconciled cash and reserves

Government, employer and household flows

UNVALIDATED

100% ELIGIBILITY DOES NOT EQUAL AN APPROVED NATIONAL LAUNCH

Payment, staffed care and transfer accounting require independent evidence.

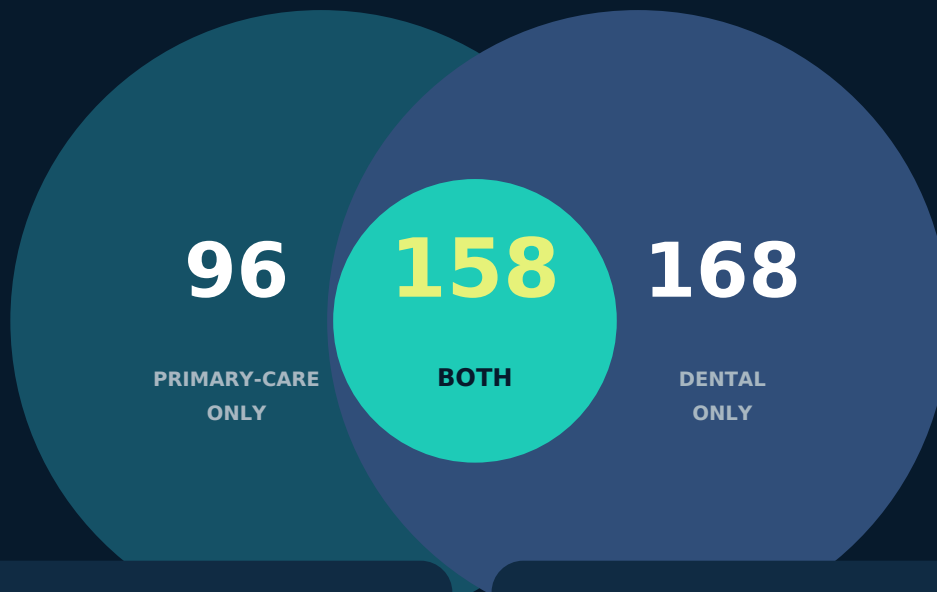
Coverage eligibility can reach 100% in the model without proving staffed care, safe reimbursement or on-time collection of sponsor funds.

Access depends on where clinicians are.

Regional workforce records expose why one insurance card cannot guarantee appointments.

3,135

COMPARABLE COUNTY RECORDS



254

**ZERO DEFINED PRIMARY-CARE
PHYSICIAN RECORDS**

326

**ZERO ACTIVE DENTIST
RECORDS**

2,713 RECORDS ARE IN NEITHER ZERO CATEGORY

The circles are schematic; no percentages imply no actual care.

These are zero entries under narrow workforce definitions, not counties without healthcare. Telehealth, cross-county care and other professionals are excluded.

9. Final feasibility verdict

GO — retain the proposal for serious policy development. The core thought experiment has identified a coherent financing-and-benefits architecture, modeled the predictable higher use of care, quantified long-horizon spending under a transparent baseline, and demonstrated that national price-setting is consequential enough to reverse the sign of a 30-year cost comparison under *some* assumed benchmarks. It has also framed the human-value question correctly: a system can be worth funding without reducing every medical bill.

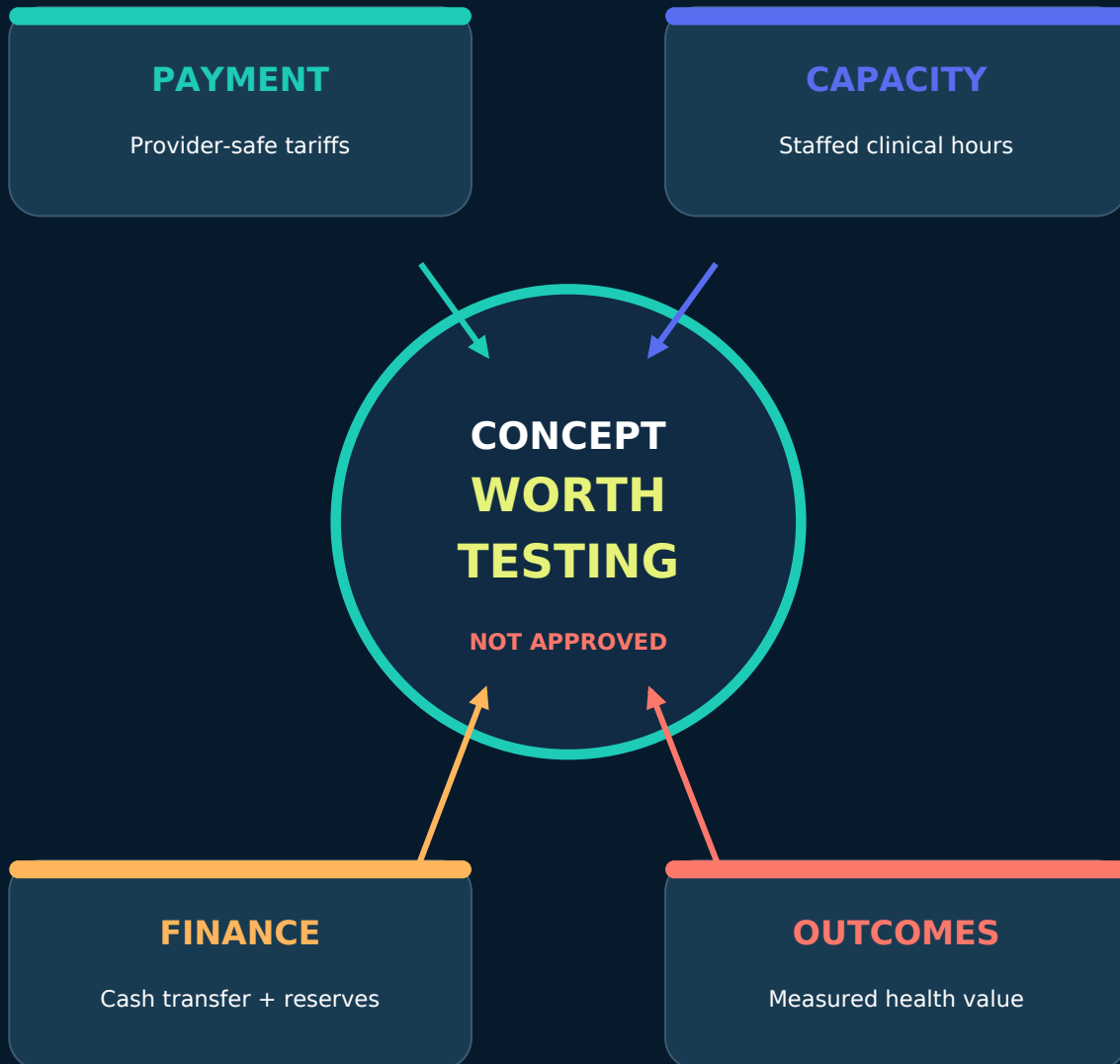
NO — do not claim certified net national savings. The exact magnitude and sustainability of regulated reimbursements, the service mix, the net added use of care, and the cost of protecting exposed providers are not resolved. The four reference-price examples cannot justify a chosen “savings forecast,” and older near-break-even or high-savings estimates are withdrawn where unsupported.

NO-GO — do not recommend implementation on current evidence. There is no verified provider-safe national tariff, a modeled and fundable cash transition, observed incremental service capacity, or measured population-level benefits sufficient to certify rollout. This is a normal boundary between **conceptual feasibility** and **implementation evidence**, not a finding that universal care is impossible.

Research stop line: The study has answered its present question. We do **not** reopen preexisting staffing, local hospital economics, individual procedure coding, tax-bracket engineering or unrelated issues as new work in this report. If a policy sponsor elects to pursue implementation, the four decision gates above define what would then need validation.

The idea merits testing. The rollout is unproven.

The next decision is whether evidence can validate four separate national constraints.



CURRENT FINANCIAL MODEL:

+\$15.681T

30-YEAR D MINUS A; RESTRICTED PRICING CASE

Conceptual feasibility does not certify safe nationwide launch. Payment, capacity, financing and measured outcomes must each pass evidence-first validation.

10. Audit trail, superseded claims, and primary sources

Status of earlier versions:

Earlier reported number	Disposition
Initial preliminary +\$9.44T/30yr D–A	Superseded by later service/payer and administration reconciliation
Initial optimistic –\$18.35T/30yr D–A	Superseded: required broad unvalidated savings or clinical offsets
Limited-price middle +\$15.681T/30yr D–A	Retained , explicitly only as the limited-price conditional case
Blended-hospital “near break-even” +\$0.155T/30yr	Withdrawn: invalid cross-denominator use of study-wide blended ratio
Four service-specific Medicare-reference cases	Retained as sensitivities only , with unresolved feasibility, source and cost caveats

Main published anchors (linked source papers/datasets, not endorsements of our extrapolations):

1. CMS, [National Health Expenditure Fact Sheet](#) and [NHE definitions, sources and methods](#) — 2024 spending, sponsor definition and service/payer logic.
2. RAND, [Prices Paid to Hospitals by Private Health Plans, Version 5.1](#) — matched sample facility-paid-to-Medicare comparisons.
3. Milliman, [Commercial Reimbursement Benchmarking Against Medicare Fee-for-Service Rates](#) — published national 2024 inpatient, outpatient and professional benchmarks (205%/263%/143%; distinct from historical scenario inputs).
4. Health Care Cost Institute, [System-Affiliated Hospitals Associated with Higher Prices](#) — employer-sponsored facility mix comparator.
5. JAMA Network Open / PubMed Central, [Study of commercial and Medicare service-specific prices](#) — sample-based inpatient, outpatient and physician ratios; denominator mismatch warning.
6. MedPAC, [March 2026 Report to the Congress](#) — context for negative Medicare hospital service margins.
7. Original national cohort references and detailed assumptions appear in the **completed model record**, *A Universal U.S. Healthcare System: Consolidated National Feasibility Model*, and associated Steps 119–124 (CMS service/payer audit, service-price bridge, nonprice-savings ledger, early-detection bridge, headcount and capacity integration). These original calculations were synthesized here; their unresolved categories have **not** been treated as newly solved.

End of conceptual study — reconciled and closed October 26, 2026.

FOUR-DOCUMENT EDITION | CONDITIONAL 100-YEAR EXTENSION

The 2025-2054 conclusions above remain unchanged. Companion Document 3 mechanically extends the printed 30-year financial scenarios to 2124. With limited-price assumptions, cumulative D–A stays positive through 2124 (+\$314.589T nominal). Three deeper-price illustrations cross cumulatively during 2040-2045, but their unlike source ratios do not establish safe tariffs, clinical capacity, transition financing, or nationally achievable savings. This is a sensitivity, not a 100-year CMS forecast. Document 4 controls the original 30-year technical record and preserved historical research.