

Worthy

Making Healthcare Accessible to Everyone





Introduction

While preparing to testify to Congress at the start of 2026, I met a Blue Shield of California member named Greg (not his real name). Greg is a healthy, active individual in his early sixties, who is a partner in a small, private business where he earns an income of around \$200,000 per year. He is also paying tuition for his two children in college.

As of January 1, 2026, for the first time in his life, Greg does not have healthcare coverage.

When the expanded Affordable Care Act tax credits expired, he was faced with a monthly health insurance bill of nearly \$5,000 to cover his entire family. Because that is more than 25% of his pre-tax income, he decided to go without coverage for himself and keep his wife and children covered — in a policy with a deductible of \$11,600. Greg has given up biking outdoors, only drives in the slow lane, and is doing everything he can to be safe and stay healthy until he becomes eligible for Medicare. He told me he had done everything right — he didn't smoke, didn't drink, and exercised regularly — yet the system has left him with no affordable option. You could feel the stress that our broken system has put on his daily life.

Greg is far from alone. Roughly 8.3%, or 28 million Americans of all ages, did not have healthcare coverage in 2025 ([CDC](#)). Because the average family healthcare coverage policy purchased through an employer is now nearly \$27,000 per year ([KFF](#)) the average American

cannot afford the average healthcare coverage premium without a substantial subsidy. The amount of financial support people receive varies, and those with lesser subsidies and/or lower incomes either go without coverage or buy healthcare coverage with very high out-of-pocket costs. In Greg's case, he did both by foregoing coverage for himself and buying a high-deductible plan for the rest of his family.

This is a serious problem. Multiple studies over the last couple of decades ([Sicker and Poorer, NCBI](#), [Excess Deaths Among Uninsured](#)) have consistently shown that people who are uninsured experience:

- A significantly higher risk of death, even after adjusting for income and employment
- Measurable declines in overall health status within just a few years
- Reduced access to preventive care, chronic disease management, and timely treatment

In addition, people who are underinsured (those who have healthcare coverage but face out-of-pocket costs they struggle to afford given their income level) can also face significant financial barriers to accessing care even if they do have coverage. Healthcare costs continue to be the leading cause of personal bankruptcy, and medical debt is strongly associated with poorer physical and mental health outcomes and higher mortality rates ([JAMA](#)).

Even if you happen to be fully insured, your health risks increase if you are living in an unhealthy community. We all learned that lesson during the COVID pandemic. Therefore, ensuring everyone in our community has good healthcare coverage is not only the right thing to do, but also in everyone's self-interest.

The good news is that in prior Worthy segments, including the last released segment advocating to put the healthcare system on a budget, we have demonstrated that it is possible to reduce healthcare costs by > \$1 trillion and ensure annual healthcare cost increases do not exceed

the increases in wages or other general prices ([will link to Segment 8A](#)). In short, we have shared a path to making healthcare affordable for our country for the foreseeable future. So the question now is: how do we ensure it is affordable and accessible to each one of us?

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All for one and one for all

To be clear, if a bit repetitive, it is important that everyone has healthcare coverage because:

- It is the right thing to do
- People without coverage live shorter, less healthy, and more stressful lives
- Our individual health is better when the health of the people living in our community is better, and they are healthier when they have healthcare coverage

Universal healthcare coverage also makes the cost of that coverage more affordable for all of us. This is not unique to healthcare coverage, but rather a feature of all situations where there is collective risk and/or insurance.

For example, if you were allowed to buy a homeowners insurance policy after your house burned down in a fire, then you could just not pay for a policy until disaster struck. Of course, if all homeowners did the same thing, then the insurance premium would have to be incredibly high to cover the cost of rebuilding as only people owning homes that have suffered damage would be buying policies. By requiring insurance before a disaster strikes, most homeowners would purchase a policy in order to avoid the potentially catastrophic financial implications of losing their homes. As a result, insurance rates are much lower than they would be in the first scenario described above.

The same holds true for healthcare coverage. If people just buy healthcare coverage when they think they need to use it, the price for that coverage becomes much more expensive for everyone. Therefore, getting everyone or nearly everyone to have healthcare coverage is an important part of making it more affordable for all and prevents individuals from gaming the system.

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[Something for everyone](#)





Something for everyone

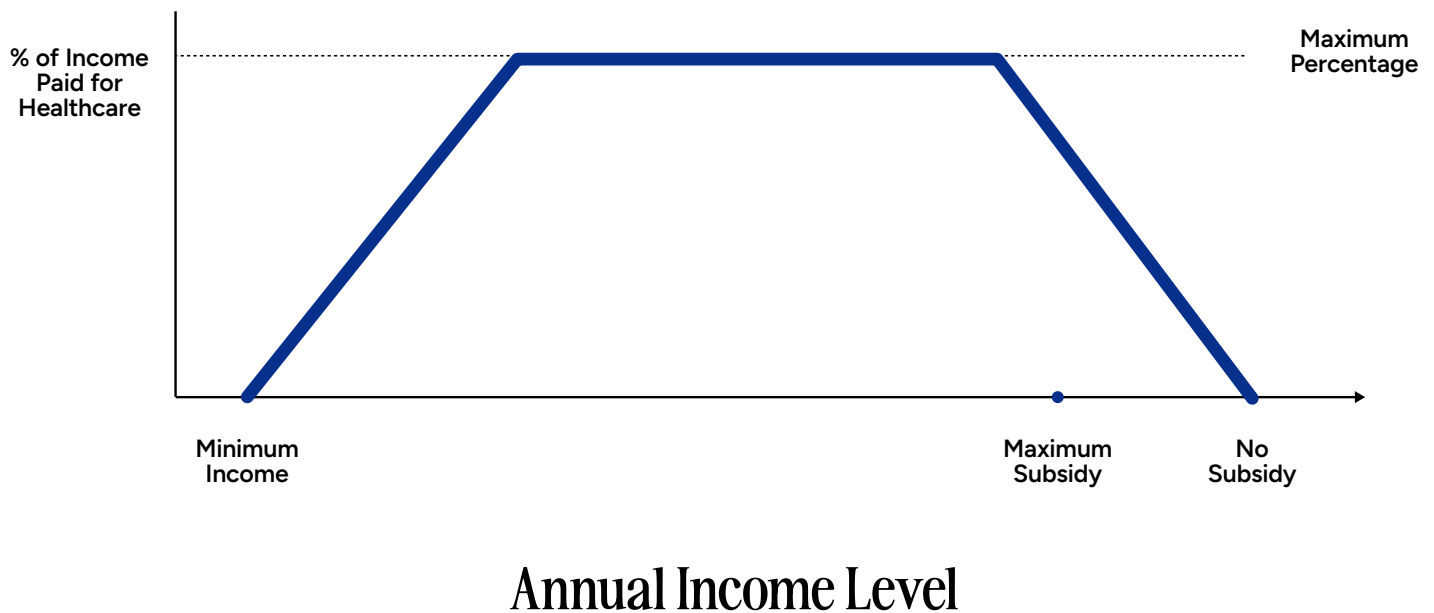
With all this in mind, the proposal for establishing universal healthcare coverage has three parts:

- Create a system of subsidies for healthcare coverage that establishes maximum percentage of income any one person or family has to pay for healthcare to ensure it is affordable for every person/family
- Establish a “default” healthcare coverage plan for anyone who does not make an election on their own so that they are automatically covered
- Give individuals the option to not take healthcare coverage through a strict opt-out process

First, make healthcare affordable for everyone. . .

As we’ve demonstrated in previous Worthy segments, the average American cannot afford the average healthcare premium without a subsidy. Because the subsidies and the incomes of the people receiving them vary, some cannot afford healthcare coverage even with subsidies, or they end up purchasing coverage with deductibles and out-of-pocket costs they cannot afford. Therefore, the first part of this proposal is to establish a system of subsidies that ensures everyone can afford coverage and their out-of-pocket costs.

The graph below depicts the proposed system of subsidies.



In this system, we would establish a minimum income that an individual or family would need to earn before they had to start paying for healthcare coverage. Below this minimum, they would be eligible for Medicaid coverage at no cost to them. Once they are above this threshold, the percentage of income they have to contribute toward healthcare coverage would increase gradually up to a maximum percentage. It probably makes sense to vary the minimum income based on the median income of each state, but others with more experience in this field should help determine these specifics. It will also be important to ensure that there are strong systems to prevent and address fraud and abuse, e.g., reporting/portraying income as much lower than it actually is to become eligible for less expensive coverage. The point is to determine what each person can afford to contribute to their healthcare based on their actual financial means.

As we get to individuals and families with higher incomes, the need for a subsidy is reduced and eventually disappears altogether. In this proposal, the subsidies would be capped and then start falling gradually until there are little or no subsidies at all. A good example of someone who doesn't need help paying for healthcare coverage is Warren Buffet, the recently retired CEO of Berkshire-Hathaway and billionaire, who is eligible for Medicare. Why should the federal government meaningfully subsidize the cost of his Medicare coverage when we have millions of uninsured and underinsured Americans?

This system of subsidies should be relatively straightforward when applied to government-sponsored programs including Medicaid, Medicare, and individual exchanges. Federally filed taxes from the prior year can be used to determine subsidy eligibility. As per the recommendations provided in the [Digitize,](#)

[Simplify, and Automate](#) Worthy segment we will have established a relatively small number of standardized and simplified benefit designs. The benefit options available to those with lower incomes would have to be limited to products with low out-of-pocket costs to ensure that each individual and family can afford not only their healthcare coverage premium but any other healthcare costs they might incur. As incomes increase, the product options available will also increase and eventually include things like a high-deductible plan. At a certain income level, the subsidy would eventually be fixed to a specific product design.

For those with employer-sponsored healthcare coverage, it is a bit more complicated. If we make all employees eligible for the same federal subsidies described above, then employers will have an incentive to stop subsidizing healthcare coverage for their employees, or the employers that continue to do so will have a cost disadvantage compared to those who do not. In any case, this could create a massive transfer of financial responsibility from the private sector to the federal government — something we simply cannot afford. There are also employers that do not offer healthcare coverage benefits to their employees today, and we do not want to overly burden businesses, particularly small businesses, with additional costs or regulations.

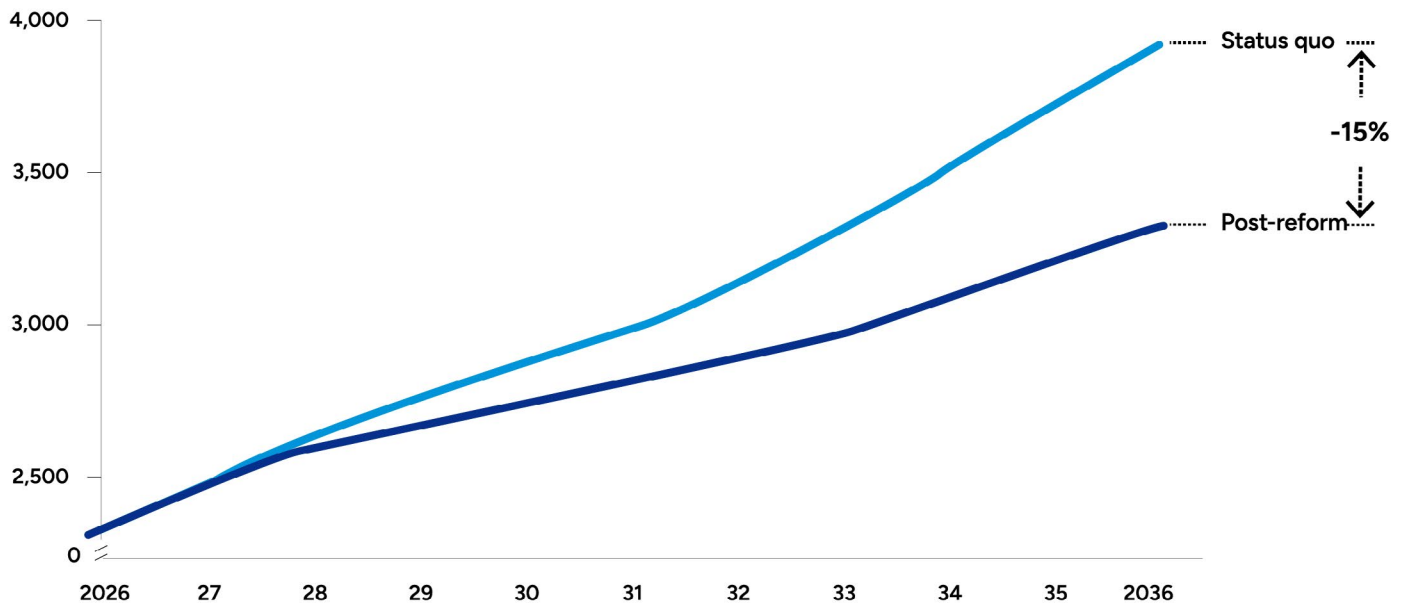
Fortunately, there is currently a mandate for many employers to provide healthcare coverage ([IRS](#)). It will be important to maintain that and perhaps strengthen it in order to ensure it continues to have its intended effect in this new system. Ideally, the amount the employer contributes to healthcare coverage will also vary based on the income level (much like payments into the Medicare system do), however, that decision will ultimately be left to each employer.

Because employers will also have confidence in the long-term affordability of healthcare cost trends, they should be more comfortable with making long-term financial commitments to subsidize healthcare coverage for their employees. Hopefully, this will encourage more of them to do just that.

When done right and coupled with the reforms described in the previous chapter to put healthcare on a budget, this should also be sustainably affordable for the federal government and help keep Medicare solvent for the foreseeable future. Granted, there is a lot of complex math and assumptions required to forecast these future costs and this will ultimately have to be analyzed by the Congressional Budget Office (CBO) and others; however, based on the assumptions and forecasts provided in the Appendix, these proposals will ultimately cost the government substantially less than what is currently being forecasted. Specifically, see the charts below which show the fiscal forecast for our proposed reforms. We estimate that by 2036, the federal government will spend up to 15% or ~\$600B less on healthcare than what is currently projected by the CBO under the status quo, or \$3.3T v. \$3.9T. The estimates are based on projections on costs and savings resulting from the following policies if they were implemented:

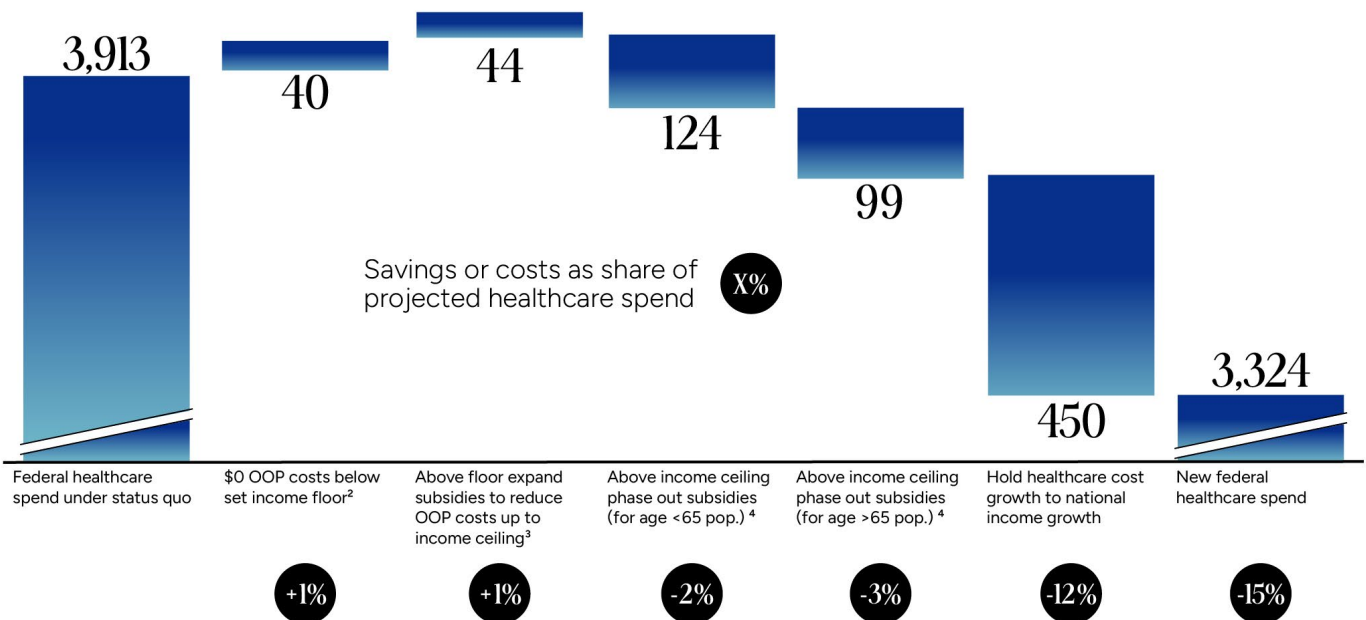
- Provide government support to ensure zero out-of-pocket healthcare costs for individuals whose incomes fall below a certain floor, which we set as being 138% of the Federal Poverty Level (FPL)
- For individuals with incomes above this floor expand government support and subsidies to enable lower maximum out-of-pocket healthcare costs. However, reduce the value of these subsidies as income increases relative to a set income ceiling. This component would apply to individuals with incomes ranging from 138%-400% of the Federal Poverty Level
- For individuals with incomes above the ceiling level of 400% of Federal Poverty Level phase out all subsidies for premium and out-of-pocket healthcare costs. Populations targeted would include employees receiving tax subsidies for employer-sponsored healthcare coverage (for ages <65) as well as Medicare beneficiaries (for age 65+). These populations would not qualify for Medicaid or subsidies under the Affordable Care Act
- To further cap costs tie healthcare cost growth to national income or Gross Domestic Product (GDP) growth consistent with the proposal for a National Office of Healthcare Affordability

Total federal healthcare spend under status quo v. under proposed reforms, \$B¹



¹ Sources and approach used described in Appendix B. Source: CBO, Commonwealth Fund

Fiscal impact of reforms by 2036 on federal healthcare spend, \$B¹



¹ Sources and approach used described in Appendix B ² Targets individuals with incomes below 136% of the federal poverty level (FPL) ³ Targets individuals with incomes ranging from 138% to 400% of FPL ⁴ Targets individuals with incomes exceeding 400% of FPL. Source: CBO, Commonwealth Fund

...Then we ensure everyone automatically gets healthcare coverage...

Now that we've set up a system that ensures affordability for everyone, the next step is to establish a "default" health benefit plan that people are enrolled in if they do not proactively choose coverage for themselves. The purpose of this is to help ensure coverage is universal and to address the human tendency of many to either procrastinate or forget to deal with unexciting tasks like signing up for healthcare coverage. For example, all those below the income level for Medicaid eligibility could default into Medicaid, and those above the income level could default into an individual "Silver" plan (Silver is a reference to a certain benefit design for health coverage offered to individuals on healthcare exchanges). Naturally, the subsidy these individuals are eligible for will be tied to their income level as described above, so they will default into a plan that they can afford. Also, under current law, those with lower incomes get financial assistance with their out-of-pocket costs, e.g., copay. That should continue and may need to be adjusted to ensure that no one faces an insurmountable financial barrier to access care even if they have healthcare coverage.

It is important to note that this default coverage approach is not a mandate. It simply ensures that if for any reason someone just doesn't bother to sign up for healthcare coverage, they still get covered. As you will see in the next section, if someone truly does not want healthcare coverage, they will have the ability to opt out of it.

...and give individuals the ability to opt out

Probably the most politically controversial aspect of the Affordable Care Act was the mandate to buy healthcare coverage. While that aspect of the law has since been made inoperative, the requirement was not popular. There were likely different reasons for this, including the worry about having to buy something unaffordable, or the sense for some that this violated the individual freedom and independence that has long been a defining characteristic of American society. Whatever the reasons, mandating healthcare coverage is simply not a politically viable path to ensuring everyone has it.

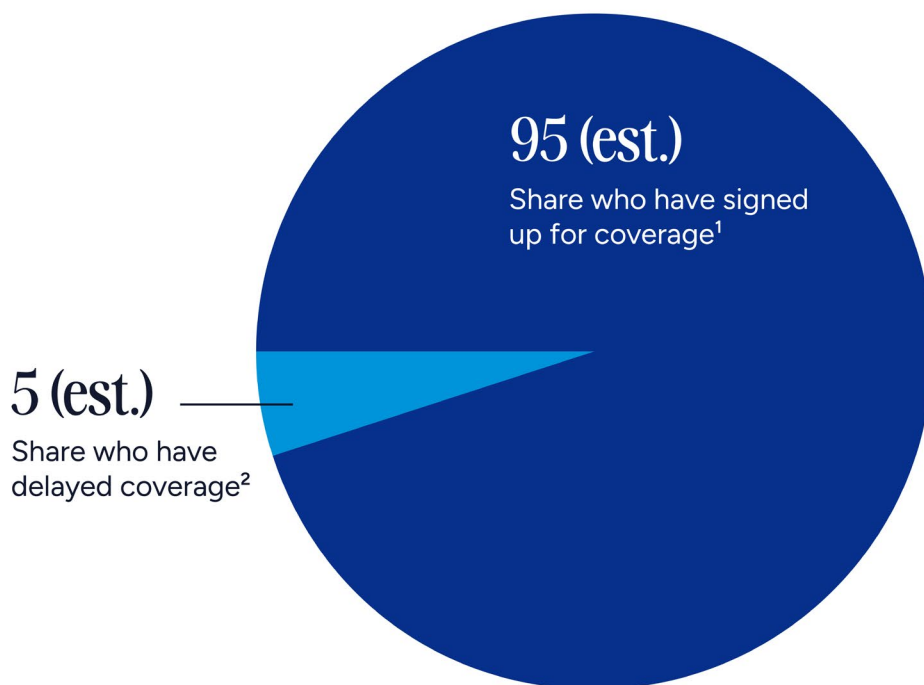
However, as we have seen earlier with the example of buying homeowners insurance, if individuals avoid buying healthcare coverage until they experience a health event and then decide to purchase it, this will raise the price of the coverage for everyone. If enough people follow this pattern, healthcare coverage will become more unaffordable and undermine everything that is proposed here.

That is why I'm recommending the default plan combined with the ability for individuals to opt out of healthcare coverage but under a strict set of rules, including financial penalties if someone wants to get healthcare coverage later. This preserves individual freedom of choice, but should also prevent the dynamic that will raise the cost of healthcare coverage for everyone else.

Medicare has a system like this. When you become eligible for the program, you don't have to take it. (If you continue to work and be eligible for healthcare benefits from your employer, you can delay joining the program as well.) However, if you decide not to join on your date of eligibility and then want to access Medicare

later, there are substantial financial penalties for doing so. The combination of how affordable the Medicare program is to people and the substantial financial penalties associated with taking the program later, mean there is near universal uptake of Medicare (see chart below).

Medicare eligible population by status, %



¹ Estimated share of individuals eligible for Medicare who have signed up for coverage; ² Estimated share of individuals who are eligible for Medicare but have delayed signing up because they have employer-based coverage. Source: Glidden Group, Census

We can follow Medicare's lead and set up a similar system for all healthcare coverage. In this system, you are not mandated to get healthcare coverage but you need to consciously opt out of having any coverage. You will sign an agreement that you understand both the financial risk that you are taking on to cover your own healthcare costs, and the financial penalties you will incur if you later decide to get healthcare coverage. This should make the practice of waiting to sign up for healthcare coverage until you need it financially unappealing, if not prohibitively

expensive, for many people. It should strongly encourage near universal participation — as there is currently with the Medicare program — while preserving individual choice, without increasing the price of healthcare coverage for others.

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A new hope

While this set of proposals has several moving parts, when done well, it will actually be a lot less complicated than our current world. The choices for individuals and employers will be simplified and clear, as a result of standardized benefit options and transparent, predictable financial contribution requirements. The financial performance expectations and the potential consequences of not meeting them for all participants in the healthcare system — health plans, hospitals, physicians, pharmaceutical companies, and others — will be equally clear. The calculations and administration of all of this should be straightforward. Using objective sources of information should also help us prevent fraud, waste, and abuse.

Perhaps most importantly, this proposal outlines a path to ensure everyone — except those who truly do not want it — has affordable healthcare coverage that is sustainable, not just for a few years, but for the foreseeable future. When it comes to healthcare in America, this represents a dramatically different path than the one we are currently on.

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The path forward

What I am proposing here absolutely can work. It will also be contentious.

Currently, people like Bill Gates, Warren Buffet, and other high-income and high net worth individuals get their healthcare coverage costs subsidized by the federal government through the Medicare program. This proposal would reduce those subsidies for some and eliminate them for others, as part of ensuring those with lower incomes can actually afford healthcare coverage. Historically, any proposed “reduction” of Medicare benefits to anyone eligible for the program has met stiff resistance. However, we will remind critics that to ensure healthcare is affordable for everyone, subsidizing healthcare costs for the rich is a luxury we simply cannot afford.

There will be plenty of other arguments against pursuing this agenda, and we will be happy to engage in the debate and explain why this can and will work. In the process, we will also insist that if critics have a better way of making healthcare universal and affordable for everyone (including affordable for the federal government and employers), they should feel free to offer it at any time.

In the meantime, to make this work, we will need new laws that do the following:

- Adopt all of the earlier Worthy proposals to make healthcare affordable, including creating a National Office of Healthcare Affordability that sets and can enforce cost targets that ultimately bring healthcare costs in line with wage inflation
- Establish a system of subsidies that ensure healthcare is affordable for everyone who needs it, and also continues the current mandate on employers to subsidize health benefits
- Establish a “default” plan for those people who do not make a proactive health coverage choice
- Create a system for individuals to opt out of healthcare coverage, including financial penalties should they later decide to opt in

We started Worthy because the healthcare system is bankrupting and failing us. It requires systemic reform, which is unlikely to come from the industry itself. So, we need new federal laws and regulations that require the healthcare industry to change. I have described this as giving the healthcare industry some “tough love.” That is, while we love much of what the participants in the system are doing for us, we need them to do it better and more efficiently as soon as possible. Our previous segment on affordability and this segment are the ultimate culmination of this approach. By setting a budget and holding all the participants in the

healthcare system accountable for hitting it, we are administering some “tough love” to the industry. The industry participants won’t like it, but they will adapt to it if we all insist that they do. And when we do insist on it, we will create a path for everyone to have access to healthcare that is both affordable and truly Worthy.

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[Appendix](#) →



Appendix: Assumptions and approach for fiscal forecast

We took the following approach to building the fiscal forecast featured in this report, which shows a 15% or ~\$600B reduction in federal healthcare spending by 2036 (\$3.32T v. \$3.91T under status quo).

- 1) For our baseline we used projections on total net federal subsidies for healthcare coverage as calculated by CBO in this [report](#). As of 2026 net federal subsidies for healthcare coverage will total \$2.36T according to CBO and will rise to \$3.91T by 2036. These data are labeled as federal healthcare spend under the status quo
- 2) We broke down the proposed reforms outlined in this paper into several potentially actionable components listed in table below
- 3) To estimate savings from these components we found similar policy options that have been previously proposed and could be proxies. These include Medicaid expansion; reinstating ACA subsidies; means-testing Medicare and the employer tax exclusion for healthcare; and tying healthcare cost growth to GDP growth. Then we aggregated savings estimates for these policies mainly from CBO reports as well as a Commonwealth Fund study
- 4) We applied savings for these policies upon implementation to the current projected federal government healthcare spend baseline from CBO

The table provides further detail on each of the individual components of our proposals and analysis, policy proxies we chose, and federal savings or cost estimates from those policies:

Component	Description	Proxy Policy	Federal Costs or Savings	Source
Federal healthcare spend under status quo	CBO projections on federal spend for healthcare subsidies through 2036	N/A	Total costs projected to increase from \$2.36T by 2026 to \$3.91T by 2036	CBO

Component	Description	Proxy Policy	Federal Costs or Savings	Source
\$0 out-of-pocket healthcare costs below set income floor	Ensure through government coverage and subsidies that individuals with incomes below set floor have no out-of-pocket healthcare costs	Medicaid expansion in non-expansion states, which similarly provides coverage and eliminates out-of-pocket costs for low-income population. This policy establishes an income floor (138% of the Federal Poverty Level) under which the government fully pays for out-of-pocket healthcare costs	\$400B in costs over 10 years, or \$40B annually by 2036. Note we rounded up Commonwealth Fund's estimate of \$366B, which was made in 2021, to account for cost growth since this time	Commonwealth Fund
Above income floor expand subsidies to reduce out-of-pocket costs up to income ceiling	Sliding scale subsidies that reduce maximum OOP costs as share of income. Subsidies decrease as the income of individuals reaches a set ceiling	Reinstate ACA premium tax subsidies, which reduces OOP costs but lowers subsidy amounts as income increases. Past income floor (138% of FPL) as income increases (up to 400% of FPL) this policy allows for higher premium contributions from this population, ranging from 0-10% of household income	\$350B in costs over 10 years, or \$44B annually by 2036	CBO, Congress.gov
Phase out subsidies for individuals above income ceiling (for age <65 population)	Above set income ceiling phase out government support for out-of-pocket healthcare costs; this component targets <age 65 population	Limit income and payroll tax exclusions for employer-sponsored healthcare coverage, which also targets higher income individuals in this age group. We targeted limiting exclusion to 75th percentile of incomes, indicating that premiums above this amount (\$12,700 per year for individuals, \$31,300 for families) would be taxed	\$871B in savings over 10 years or \$99B annually by 2036. Savings come from limiting the employer tax exclusion to a percentile of premiums (selected 75th). Note that for this proposal we estimated outer-year savings as this was not published by CBO (e.g. years 9 and 10, or 2035 and 2036)	CBO

Component	Description	Proxy Policy	Federal Costs or Savings	Source
Phase out subsidies for individuals above income ceiling (for age >65 population)	Above set income ceiling phase out government support for out-of-pocket healthcare costs; this component targets >age 65 population	Means-test and require higher income individuals in this age group to pay more in Medicare Part B premiums. We focused on a policy that would ramp up Part B premiums to cover up to 35% of expected healthcare costs after 5 years	\$609B in savings over 10 years or \$124B annually by 2036. Savings come from means testing Medicare Part B premiums. Note that for this proposal we estimated outer-year savings as this was not published by CBO (e.g. years 9 and 10, or 2035 and 2036)	CBO
Hold healthcare cost growth to a budget under which it is not allowed to exceed national income growth	Hold rate of healthcare cost growth to national income or GDP growth	Compare CBO's projections on federal healthcare cost growth (5.2% p.a. increase or 65% overall from 2026-2036) to rate of growth for GDP (3.9% p.a. increase or 46% overall from 2026-2036). If we held healthcare cost growth to GDP growth it would produce a large gap, which we use as savings estimate	\$1.73T in savings over 10 years or \$450B annually by 2036	CBO, CBO
New federal healthcare spend	New federal healthcare spend after applying costs and savings of reforms to CBO baseline spend under status quo	Cumulative impact of all policies and components included in analysis	\$2.46T in savings over 10 years or ~\$600B annually by 2036	



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