# THE MESOCRATIC PARTY | POLICY WHITE PAPER

# The Two-Tier Plan

## Universal Baseline Coverage with a Private Supplemental Market

### See a doctor. Not a bill. And not a 6-month wait.

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## Table of Contents

**Executive Summary**

**1. The Problem: The Most Expensive Failure in the World**

- 1.1 What America Spends
- 1.2 What America Gets
- 1.3 Where the Money Goes
- 1.4 The Insurance Incentive Problem

**2. The Data: How Other Countries Do It Better**

- 2.1 Two-Tier Systems: The International Standard
- 2.2 The International Comparison Table

**3. The Proposal: How the Two-Tier System Works**

- 3.1 Tier 1: Universal Baseline Coverage (Public)
- 3.2 Tier 2: Supplemental Private Insurance (Optional)
- 3.3 Drug Pricing Reform

**4. The Math: What It Costs**

- 4.1 Current Spending
- 4.2 Projected Cost of Universal Baseline
- 4.3 Revenue Equivalence Analysis
- 4.4 The Key Insight

**5. Who Benefits**

- 5.1 Impact by Group

- 5.2 Honest Trade-Offs

**6. Implementation**

- 6.1 Phase 1: Foundation
- 6.2 Phase 2: Expansion
- 6.3 Phase 3: Universal Coverage

**7. How the Parties Compare on Healthcare**

**8. Conclusion**

**Sources and References**


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## Executive Summary


The United States spends more on healthcare than any country on earth — $5.3 trillion in 2024, or roughly $15,500 per person. That is 18% of the nation's entire economic output. It is more than double the per-capita spending of most developed countries.

And for that money, Americans get worse outcomes.

Life expectancy in the U.S. is lower than in every comparable wealthy nation. Infant mortality is higher. Chronic disease rates are higher. Roughly 27 million Americans are uninsured. Tens of millions more are underinsured — they have coverage on paper but cannot afford to use it. Medical debt is the leading cause of personal bankruptcy. More than one in four Americans report skipping medical care because of cost.

The system is not failing because Americans don't spend enough. It is failing because the system is structurally broken: administrative overhead consumes roughly 30% of every healthcare dollar, insurance companies profit by denying claims, pharmaceutical companies charge Americans more than any other country on earth, and the entire apparatus is so complex that navigating it is itself a barrier to care.

The Mesocratic Party proposes replacing this system with a two-tier model: a universal public baseline that covers every American from birth for essential medical services, and a private supplemental market for those who want more. This is not a theoretical idea. It is how healthcare works in Australia, Germany, France, and the United Kingdom — countries that spend less per person, cover everyone, and consistently outperform the U.S. on nearly every health outcome metric.

Key findings of this paper:

- The U.S. spent $5.3 trillion on healthcare in 2024 — $15,474 per person — more than double the average of comparable wealthy nations ($6,651 per person in OECD peer countries, 2023).

- Administrative costs in the U.S. healthcare system consume approximately $1,078 per capita, far exceeding peer nations. Administrative overhead accounts for roughly 30% of total healthcare spending.
- Countries with two-tier systems (Australia, Germany, France) spend 10-12% of GDP on healthcare vs. 18% in the U.S., while achieving higher life expectancy, lower infant mortality, and universal coverage.
- Australia's two-tier system — public Medicare plus optional private insurance — ranked 3rd globally in the Commonwealth Fund's international comparison and 1st in health equity and healthcare outcomes, while spending approximately $10,000 per person (vs. $15,500 in the U.S.).
- A universal public baseline funded through federal revenue, combined with drug pricing reform and administrative simplification, can achieve universal coverage while reducing total national healthcare expenditure.

The question is not whether America can afford universal healthcare. America already spends more than enough. The question is why it gets so little for so much.

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## 1. The Problem: The Most Expensive Failure in the World

### 1.1 What America Spends

The United States spent $5.3 trillion on healthcare in 2024. That figure has grown relentlessly: from $74 billion in 1970, to $1.4 trillion in 2000, to $4.9 trillion in 2023, to $5.3 trillion in 2024. Healthcare spending now accounts for 18% of GDP — nearly one in every five dollars the economy produces.

On a per-capita basis, the U.S. spent $15,474 per person in 2024. The next closest wealthy nation — Switzerland — spent approximately $9,700 per person (2023 OECD data). The average for comparable wealthy OECD countries was $6,651 per person. The U.S. spends more than double the peer average.

| Country | Per Capita Health Spending (2023) | % of GDP |
|---|---|---|
| United States | $13,432* | 17.6% |
| Switzerland | ~$9,700 | 11.8% |
| Germany | ~$8,300 | 12.7% |
| Australia | ~$6,200 | 10.1% |
| France | ~$6,500 | 12.1% |
| United Kingdom | ~$5,600 | 11.3% |
| Canada | ~$6,300 | 12.1% |
| OECD Comparable Avg. | ~$6,651 | 11.5% |

*2023 OECD figure. CMS NHE reports $15,474 per capita for 2024. Sources: OECD Health Statistics 2024; Peterson-KFF Health System Tracker; CMS National Health Expenditure data.

### 1.2 What America Gets

For the highest healthcare spending on earth, the United States has:

- Lower life expectancy than every comparable wealthy nation. U.S. life expectancy is approximately 77.5 years, compared to 83+ in Australia, Japan, and Switzerland.
- Higher infant mortality. The U.S. infant mortality rate is roughly 5.4 per 1,000 live births — nearly double the rate in countries like Japan, Finland, and Sweden.
- Higher rates of chronic disease. The U.S. has higher rates of obesity, diabetes, and heart disease than most peer nations.
- 27 million uninsured Americans, despite spending more than any country.
- More than one in four Americans report skipping care because of cost, including people with insurance.
- Medical debt as the leading cause of personal bankruptcy.

The Commonwealth Fund's international comparison ranked the U.S. last overall among 11 wealthy nations in healthcare system performance. The U.S. ranked last in access to care, last in equity, and last in administrative efficiency.

Australia — which operates the closest model to what the Mesocratic Party proposes — ranked 3rd overall, 1st in equity, and 1st in healthcare outcomes.

### 1.3 Where the Money Goes

The U.S. healthcare spending breakdown (2024, CMS data):

- Hospital care: $1.6 trillion
- Physician and clinical services: $1.1 trillion
- Prescription drugs: ~$450 billion (retail)
- Private health insurance administration: ~$300 billion
- Government administration: ~$75 billion
- Other (dental, home health, nursing care, equipment): remainder

The single most striking feature of U.S. healthcare spending is the administrative burden. The U.S. spends approximately $1,078 per capita on healthcare administration — more than four times the average of peer nations. Americans spend roughly $8,350 per person on inpatient and outpatient care, compared to $3,636 in comparable countries.

This overhead is not a bug. It is the business model. The U.S. healthcare system contains roughly 900 private insurance companies, each with its own networks, formularies, billing codes, prior authorization requirements, and claims processes. Hospitals employ more billing staff than clinical staff in many cases. Physician practices spend an estimated 15-25% of revenue on billing and insurance-related administration.

### 1.4 The Insurance Incentive Problem

Private health insurance in the United States operates on a structural conflict of interest: insurers profit by collecting premiums and denying claims. Every dollar not spent on care is a dollar of profit.

This incentive produces:

- Prior authorization requirements that delay treatment for weeks or months.
- Narrow provider networks that restrict which doctors patients can see.
- Claim denials that require patients to navigate appeals processes.
- Surprise billing for out-of-network care that patients didn't choose.
- Administrative complexity that burdens both patients and providers.

The Affordable Care Act's Medical Loss Ratio (MLR) requirements mitigated some of this by requiring insurers to spend at least 80-85% of premiums on care. But the remaining 15-20% — hundreds of billions of dollars — is still spent on administration, marketing, executive compensation, and profit.

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## 2. The Data: How Other Countries Do It Better

### 2.1 Two-Tier Systems: The International Standard

Most wealthy democracies use some form of two-tier healthcare system: a public universal tier that covers everyone, and a private supplemental tier for those who want more. The specific structures vary, but the principle is consistent.

**Australia (Medicare + Private Health Insurance)**

Australia's Medicare provides universal coverage for all citizens and permanent residents, funded through general taxation and a Medicare levy (1.5-2.5% of taxable income). Medicare covers GP visits, public hospital care, and subsidized prescription drugs. Approximately 44% of Australians also carry private health insurance for private hospitals, dental, optical, and shorter wait times.

Australia spends approximately 10.1% of GDP on healthcare. Life expectancy is approximately 83 years. The Commonwealth Fund ranked Australia 3rd overall, 1st in equity, and 1st in healthcare outcomes.

**Germany (Statutory Health Insurance + Private)**

Germany operates a dual system: statutory health insurance (GKV) covers roughly 87% of the population through nonprofit sickness funds, funded by payroll contributions. Higher earners can opt out into private insurance (PKV). Both systems provide comprehensive coverage.

Germany spends approximately 12.7% of GDP on healthcare with universal coverage and some of the shortest wait times in Europe.

**France (Sécurité Sociale + Mutuelle)**

France's national health insurance covers approximately 70-80% of costs for all residents. Supplementary insurance (mutuelle), held by approximately 95% of the population, covers the remainder. The system is funded through payroll taxes and general taxation.

France spends approximately 12.1% of GDP on healthcare. The WHO has ranked France's healthcare system among the best in the world for quality and access.

**United Kingdom (NHS + Private)**

The UK's National Health Service provides free-at-point-of-use care for all residents, funded through general taxation. Approximately 11% of the population holds private insurance for faster access to elective procedures and private hospital rooms.

The UK spends approximately 11.3% of GDP on healthcare — among the lowest of wealthy nations.

### 2.2 The International Comparison Table

| | United States | Australia | Germany | France | UK |
|---|---|---|---|---|---|
| System type | Mixed private/public | Two-tier (Medicare + private) | Two-tier (statutory + private) | Two-tier (Séc. Sociale + mutuelle) | NHS + private |
| Coverage | ~92.5% | ~100% | ~100% | ~100% | ~100% |
| % GDP on health | 18.0% | 10.1% | 12.7% | 12.1% | 11.3% |
| Per capita spending | $15,474 | ~$10,037 (AUD-adjusted) | ~$8,300 | ~$6,500 | ~$5,600 |
| Life expectancy | 77.5 | 83.2 | 80.9 | 82.5 | 81.3 |
| Admin costs (% of total) | ~30% | ~12% | ~5-7% | ~5-7% | ~3-5% |
| Commonwealth Fund rank | 11th (last) | 3rd | 5th | 8th | 4th |

Sources: OECD Health Statistics 2024; CMS NHE; WHO; Commonwealth Fund Mirror Mirror 2021; AIHW.

Every two-tier country on this list spends less than the United States, covers everyone, and achieves better outcomes. The differences are not marginal. They are enormous.

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## 3. The Proposal: How the Two-Tier System Works

### 3.1 Tier 1: Universal Baseline Coverage (Public)

Every American is covered, from birth, for essential medical services. No premiums. No deductibles for baseline services. Funded through federal revenue.

**What Tier 1 covers:**

- Primary care (doctor visits, checkups, screenings)
- Emergency care
- Hospitalization (standard ward)
- Mental health services
- Preventive care (vaccinations, cancer screenings, wellness exams)
- Maternal and newborn care
- Prescription drugs (covered under a national formulary, subject to federal price negotiation)
- Chronic disease management (diabetes, heart disease, asthma, etc.)
- Substance abuse treatment
- Pediatric care
- Basic dental (preventive)
- Basic vision (exams, standard lenses)

**How Tier 1 is funded:**

The baseline is funded through federal general revenue — not a new payroll tax and not a separate premium. The U.S. government already spends approximately $2 trillion per year on healthcare through Medicare, Medicaid, ACA subsidies, VA healthcare, CHIP, and federal employee health programs. Consolidating these programs into a single baseline system, combined with administrative savings and drug pricing reform, provides the funding foundation.

**How Tier 1 reimburses providers:**

Providers are reimbursed at standardized rates set through a transparent, publicly available fee schedule — similar to Medicare's current reimbursement model but simplified and updated. Providers can accept Tier 1 patients, Tier 2 (private) patients, or both.

### 3.2 Tier 2: Supplemental Private Insurance (Optional)

Americans who want additional coverage can purchase supplemental insurance from private companies competing in an open market. Tier 2 is entirely optional and covers services and amenities above the baseline.

**What Tier 2 covers:**

- Private hospital rooms

- Elective and cosmetic procedures
- Expanded provider networks (choose any doctor, any specialist)
- Shorter wait times for non-emergency procedures
- Concierge medicine
- Enhanced dental and vision
- Alternative and complementary medicine
- International coverage
- Any service or amenity the market demands

**How Tier 2 works:**

Private insurers compete on price, coverage, and service quality. The market is regulated to prevent fraud and ensure solvency, but coverage decisions, pricing, and network design are left to the private sector. Employers can continue to offer supplemental insurance as a benefit.

This preserves the private insurance industry, preserves consumer choice, and preserves competition — while removing the private sector's role as the gatekeeper to basic medical care.

### 3.3 Drug Pricing Reform

The United States pays more for prescription drugs than any country on earth. Americans subsidize pharmaceutical company profits while the same medications are sold for a fraction of the cost in Canada, Europe, and Australia.

The Mesocratic Party supports:

- **Federal negotiation of drug prices** for all medications covered under the Tier 1 formulary. The government is the largest buyer of prescription drugs. It should negotiate like one. The Inflation Reduction Act's Medicare drug negotiation provision demonstrated the principle; the Two-Tier Plan extends it to the entire baseline population.
- **Transparent pricing** requirements for all pharmaceutical companies operating in the United States. Americans should know what a drug costs to manufacture, what other countries pay for it, and what they are being charged.
- **Importation reform** allowing Americans to purchase FDA-approved medications from certified international pharmacies at competitive prices.
- **Patent reform** preventing "evergreening" — the practice of making minor modifications to existing drugs to extend patents and block generic competition.

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## 4. The Math: What It Costs

### 4.1 Current Spending

Total U.S. healthcare spending in 2024: approximately $5.3 trillion.

Federal government healthcare spending (2024): approximately $2.1 trillion, including:

- Medicare: $1.1 trillion
- Medicaid (federal share): ~$600 billion
- ACA Marketplace subsidies: ~$100 billion
- VA healthcare: ~$100 billion
- CHIP and other programs: ~$200 billion

State and local government healthcare spending: approximately $800 billion.

Private spending (insurance + out-of-pocket): approximately $2.4 trillion.

### 4.2 Projected Cost of Universal Baseline

The cost of universal baseline coverage depends on three variables: the scope of covered services, provider reimbursement rates, and administrative efficiency.

**Administrative savings:** The single largest source of savings is administrative simplification. The U.S. currently spends approximately 30% of healthcare dollars on administration. Two-tier countries average 5-12%. Reducing administrative overhead from 30% to 15% (a conservative target, still above international norms) on $5.3 trillion in spending yields approximately $800 billion in annual savings.

**Drug pricing savings:** Federal price negotiation for the Tier 1 formulary, based on international reference pricing, could reduce pharmaceutical spending by an estimated 20-40%. On approximately $450 billion in retail drug spending, this yields $90-180 billion in savings.

**Simplified billing and insurance processing:** Standardized billing codes, a single payer for baseline services, and elimination of prior authorization for baseline-covered services dramatically reduce provider administrative burden. Estimated savings: $100-200 billion.

**Total potential savings: $990 billion to $1.18 trillion annually.**

### 4.3 Revenue Equivalence Analysis

| Component | Amount |
|---|---|
| Current federal healthcare spending | ~$2.1 trillion |
| Current state/local healthcare spending | ~$800 billion |
| Administrative savings (30% → 15%) | +$800 billion |
| Drug pricing savings | +$90-180 billion |
| Provider billing simplification | +$100-200 billion |
| Total available for baseline | ~$3.9-4.1 trillion |
| Estimated cost of universal baseline | ~$3.5-4.0 trillion |
| Net position | Roughly revenue neutral |

These estimates are conservative. They assume reimbursement rates comparable to current Medicare rates, full coverage of the baseline benefit package, and modest administrative efficiency gains. Under more aggressive efficiency assumptions, the system generates a surplus that could be used to expand coverage or reduce the tax burden.

### 4.4 The Key Insight

The United States already spends enough to provide universal healthcare. The money is there. It is simply being consumed by administrative overhead, pharmaceutical pricing, insurance company profit, and systemic inefficiency.

The Two-Tier Plan does not require Americans to spend more on healthcare. It requires them to spend what they already spend — but better.

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## 5. Who Benefits

### 5.1 Impact by Group

**Uninsured Americans (27 million):** Covered, immediately. No premiums, no deductibles for baseline services.

**Underinsured Americans (tens of millions):** Coverage that actually works. No surprise bills. No claim denials for baseline services. No fear of bankruptcy from a medical emergency.

**Employer-covered Americans:** Employers can continue offering supplemental (Tier 2) insurance as a benefit, at lower cost, because the baseline is already covered publicly. Employers currently spend approximately $23,000 per year on family health insurance premiums. Under the Two-Tier Plan, supplemental-only coverage would cost a fraction of that.

**Medicare recipients:** Existing Medicare beneficiaries transition seamlessly into Tier 1, which provides equivalent or expanded coverage with simplified administration.

**Providers (doctors, hospitals, clinics):** Simplified billing, standardized reimbursement, dramatically reduced paperwork. Physicians spend an estimated 15-25% of revenue on billing and insurance administration. Under Tier 1, billing is a single, standardized process.

**Private insurers:** The baseline eats the bottom of the private insurance market. Insurers that currently sell basic coverage to healthy, low-risk individuals would lose that market. However, the supplemental market (Tier 2) creates a new competitive landscape for premium services, expanded networks, and convenience. Insurers that adapt will compete on value-added services rather than on gatekeeping basic care.

**Pharmaceutical companies:** Drug prices fall for baseline-covered medications through federal negotiation. Companies retain pricing freedom for non-baseline drugs and for the international market. Innovation incentives remain intact through patent protection and market exclusivity for genuinely novel therapies.

### 5.2 Honest Trade-Offs

The Mesocratic Party believes in transparency about trade-offs:

- **Wait times for elective procedures may increase under Tier 1.** This is the most common concern with universal systems, and it is legitimate. The Two-Tier structure mitigates this: Americans who want faster access can purchase Tier 2 supplemental insurance. Emergency and urgent care is unaffected.
- **Some providers may see lower reimbursement** if their current rates exceed the standardized Tier 1 fee schedule. Specialists who command premium fees may see baseline reimbursement decline, offset by reduced administrative burden and the option to treat Tier 2 patients at market rates.
- **Transition disruption is real.** Moving from 900+ private insurers to a unified baseline system does not happen overnight. Phased implementation over 3-5 years is essential.
- **Tax burden may shift.** While total national healthcare spending decreases, the federal tax burden increases as public funding replaces private premiums. The net effect for most Americans is positive (lower total healthcare costs), but the mechanism changes.

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## 6. Implementation

### 6.1 Phase 1: Foundation (Years 1-2)

- Establish the Tier 1 benefit package, fee schedule, and formulary through an independent federal healthcare board.
- Begin federal drug price negotiation for the Tier 1 formulary (expanding the IRA framework).
- Set national administrative standards: standardized billing codes, simplified claims processing, electronic health record interoperability.
- Define Tier 2 regulatory framework for supplemental insurance market.

### 6.2 Phase 2: Expansion (Years 2-4)

- Extend Tier 1 coverage to all uninsured Americans and those currently covered by Medicaid.
- Medicare beneficiaries transition to Tier 1 (with equivalent or expanded benefits).
- Children covered universally from birth.
- Employers begin transitioning from full-coverage plans to Tier 2 supplemental plans.

### 6.3 Phase 3: Universal Coverage (Years 4-5)

- All Americans covered under Tier 1.
- Private insurance transitions fully to Tier 2 supplemental market.
- Administrative consolidation complete: single payer for baseline, competitive market for supplemental.

- Drug pricing reform fully implemented.

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## 7. How the Parties Compare on Healthcare

| | Republican | Mesocratic | Democrat |
|---|---|---|---|
| Coverage goal | Market-driven access | Universal baseline for all | Universal coverage |
| System structure | Private market with safety net | Two-tier (public baseline + private supplemental) | Single-payer or expanded public option |
| Private insurance role | Primary | Supplemental (Tier 2) | Eliminated (single-payer) or competing (public option) |
| Drug pricing | Market-based | Federal negotiation for baseline | Federal negotiation + price controls |
| Provider choice | Market-driven networks | Tier 1 standardized + Tier 2 open market | Government-set (single-payer) or mixed |
| Funding | Private premiums + limited subsidies | Federal revenue (replaces premiums) | Tax-funded |
| International model | None (uniquely American) | Australia, Germany, France | Canada, UK (NHS) |
| Admin efficiency | Low priority | Central priority (~30% → 15%) | Central priority |

The Mesocratic position is distinct because it preserves a role for the private market (Tier 2) while removing the private sector as the gatekeeper to basic care. It does not eliminate private insurance — it redirects it to where the market works best: competition on premium services and consumer choice. And it uses the international two-tier model, which has been tested in multiple countries for decades, rather than proposing an untested American experiment.

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## 8. Conclusion

The United States spends more per person on healthcare than any nation on earth and gets less for it than nearly every comparable country. The system is not failing because of insufficient funding. It is failing because of structural dysfunction: administrative bloat, pharmaceutical pricing, insurance company incentives, and a patchwork of programs that cover some people well, some people poorly, and 27 million people not at all.

The Two-Tier Plan fixes the structure.

Tier 1 covers every American for essential medical services, funded publicly, with no premiums and no deductibles. The government pays for basic care the way it already pays

for basic education, basic infrastructure, and national defense — because healthcare, like those things, is a baseline requirement for a functioning society.

Tier 2 preserves the private market for everything above the baseline. If you want a private room, a specific specialist, a shorter wait, or concierge medicine — buy supplemental insurance. The market competes on quality and convenience. Innovation thrives. Consumer choice is preserved.

This is not a radical idea. It is how healthcare works in Australia, Germany, France, and the UK. These countries spend less, cover everyone, and get better outcomes. The model exists. The data is available. The math works.

The United States spends $5.3 trillion a year on healthcare. That is more than enough to cover every American. The money isn't the problem. The system is.

Fix the system. Cover everyone. Let the market compete where the market works. That's the plan.

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