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## How Much Would National Health Care Cost?

*Editors' Note: With the recent resurgence of interest in controlling health care costs, we thought a review of some of the state and national fiscal studies performed on single payer over the years might be useful.*

### National Studies

#### June, 1998, Economic Policy Institute

"In the model presented in this paper, it is assumed that in the first year after implementing a universal, single-payer plan, total national health expenditures are unchanged from baseline. If expenditures were higher than baseline in the first few years, then additional revenues above those described here would be needed. However, these higher costs would be more than offset by savings which would accrue within the first decade of the program."

Universal coverage could be financed with a 7 percent payroll tax, a 2 percent income tax, and current federal payments for Medicare, Medicaid, and other state and federal government insurance programs. A 2 percent income tax would offset all other out-of-pocket health spending for individuals. "For the typical, middle income household, taxes would rise by \$731 annually. For fully 60% of households, the increase would average about \$1,600...costs would be redistributed from the sick to the healthy, from the low- and middle-income households to those with higher incomes, and from businesses currently providing health benefits to those that do not.

"Even more important, greater efficiency and improved cost containment would become possible, leading to sizable savings in the future. The impediment to fundamental reform in health care financing is not economic, but political. Political will, not economic expertise, is what will bring about this important change."

("Universal Coverage: How Do We Pay For It?" - Edie Rasell, M.D. PhD.) Hard copies available from the PNHP National Office: 29 E. Madison, Suite 602, Chicago, IL 60602

#### December, 1993 Congressional Budget Office

S491 (Senator Paul Wellstone's single payer bill) would raise national health expenditures above baseline by 4.8% in the first year after implementation. However, in subsequent years, improved cost containment and the slower growth in spending associated with the new system would reduce the gap between expenditures in the new system and the baseline. By year five (and in subsequent years) the new system would cost less than baseline. ("S.491, American Health Security Act of 1993")

#### July, 1993 Congressional Budget Office

"Enactment of H.R. 1300 [Russo's single payer bill] would raise national health expenditures at first, but reduce spending about 9 percent in 2000. As the program was phased in, the administrative savings from switching to a single-payer system would offset much of the increased demand for health care services. Later, the cap on the growth of the national health budget would hold the rate of growth of spending below the baseline. The bill contains many of the elements that would make its limit on expenditures reasonably likely to succeed, including a single payment mechanism, uniform reporting by all providers, and global prospective budgets for hospitals and nursing homes." ("Estimates of Health Care Proposals from the 102<sup>nd</sup> Congress")

#### **April, 1993 Congressional Budget Office**

"Under a single payer system with co-payments ...on average, people would have an additional \$54 to spend...more specifically, the increase in taxes... would be about \$856 per capita...private-sector costs would decrease by \$910 per capita, the net cost of achieving universal insurance coverage under this single payer system would be negative."

"Under a single payer system without co-payments people would have \$144 a year less to spend than they have now, on average...consumer payments for health would fall by \$1,118 per capita, but taxes would have to increase by \$1,261 per capita to finance this plan." ("Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates")

#### **December, 1991 Congressional Budget Office**

"[I]f the nation adopted...[a] single-payer system that paid providers at Medicare's rates, the population that is currently uninsured could be covered without dramatically increasing national spending on health. In fact, all US residents might be covered by health insurance for roughly the current level of spending or even somewhat less, because of savings in administrative costs and lower payment rates for services used by the privately insured. The prospects for controlling health care expenditure in future years would also be improved." ("Universal Health Insurance Coverage Using Medicare's Payment Rates")

#### **June, 1991 General Accounting Office**

"If the US were to shift to a system of universal coverage and a single payer, as in Canada, the savings in administrative costs [10% of health spending] would be more than enough to offset the expense of universal coverage" ("Canadian Health Insurance: Lessons for the United States," 90 pgs. Full text available online at [www.gao.gov](http://www.gao.gov)).

### **State Studies**

#### **2002: California**

##### **State Health Care Options Project**

A study of nine options for covering California's seven million uninsured by the conservative D.C.-based consulting firm of Lewin, Inc. finds that a single payer system of government financing of health care in California would actually reduce health spending while protecting the doctor-patient relationship.

"This study shows single payer is the only system that guarantees that every one of the 34 million Californians would get the health care they need when they really need it -- and does so at a savings to us all, said Don McCanne, M.D., president of Physicians for a

National Health Program. "The findings apply equally to other states as to California."

"As physicians, we know that protecting the doctor-patient relationship is at the core of providing good care. The Lewin study demonstrates again that a system with government financing like Medicare stabilizes care for patients. The current system that treats health care as a commodity to be bought and sold disrupts care incessantly while driving up costs," said McCanne.

Single payer financing saves billions by reducing waste on paperwork and overhead. A 1991 study by the U.S. General Accounting Office predicted administrative savings of 10% of health spending with a national single payer system (over \$140 billion in 2002).

Full text of all studies available online at:

<http://www.healthcareoptions.ca.gov/doclib.asp>

### **August, 2001: Vermont**

#### **Universal Health Care Makes "Business Sense"**

Single-payer universal health coverage could save Vermonters more than \$118 million a year over current medical insurance costs and cover every Vermonter in the process, according to a study paid for by a federal grant and prepared for the Office of Vermont Health Access by the Lewis Group.

"Our analysis indicates that the single payer model would cover all Vermont residents, including the estimated 51,390 uninsured persons in the state, while actually reducing total health spending in Vermont by about \$118.1 million in 2001 (i.e., five percent). These savings are attributed primarily to the lower cost of administering coverage through a single government program with uniform coverage and payment rules."

-- "Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont", The Lewin Group, Inc.

Full text of the study is available online at:

<http://www.dsw.state.vt.us/districts/ovha/spgappendixf.pdf>

### **June, 2000: Maryland**

#### **Single Payer Would Save Money in Maryland**

A single-payer system in the state of Maryland could provide health care for all residents and save \$345 million on total health care spending in the first year, according to a study by the D.C.-based consulting firm Lewin, Inc. The study also found that a highly regulated "pay or play" system (in which employers either provide their workers with coverage or pay into a state insurance pool) would increase costs by \$207 million.

Editors' Note: The pro-business Lewin group probably underestimated the administrative savings from single payer and overestimated the administrative savings (and hence understated the costs) of their "pay or play" model. Data from hospitals in Hawaii, where there are only 3 major insurers, suggest that if you have more than one payer, there are few administrative savings. However single-payer systems in Canada, the U.K., Sweden and other countries have garnered administrative savings substantially larger than assumed by Lewin. Hence the estimate by Lewin that single-payer universal coverage would cost \$550 million less to implement in the first year than "pay or play" is conservative.

Full text of the study available online at:  
<http://www.healthcareforall.com/Lewincov.htm>

### **December, 1998: Massachusetts**

#### **Two estimates for the Massachusetts Medical Society:**

- Lewin Group
- Solutions for Progress/Boston University School of Public Health (SFP/BUSPH)

“In early 1997, the Massachusetts Medical Society retained the services of two consulting teams to independently analyze the relative costs of a Canadian-style single-payer system, and the current multi-payer health care system in Massachusetts.”

“While Lewin and SFP/BUSPH reports differed in their orientations and methodologies, they reached similar conclusions. First, a single-payer system would achieve significant administrative savings [between \$1.8 and \$3.6 billion] over the current multi-payer system. Secondly, these savings are of such a magnitude that the available funds would be sufficient to insure universal coverage in the state and provide comprehensive benefits including outpatient medications and long-term care and eliminate all out-of-pocket payments (copayments, deductibles).”

“The major difference in the studies findings had to do with the timing of achieving the cost savings. SFP/BUSPH estimated that the savings could be in the first year of implementation of the system. Lewin felt the savings would begin in year six.”

--Massachusetts Medical Society House of Delegates Report 207, A-99 (B)

Full text of the studies are available online at:

<http://www.massmed.org/pages/lewin.asp>