

Paying for a Single Payer National Health Insurance Program: Where Will the Money Come from?

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How would national health insurance be paid for? Can we afford universal health care? These are among the questions we hear most often when we propose a national health program.

Dr. Edith Rasell (who was to have spoken at this forum but was forced to cancel by the blizzard) wrote in 1998 that “universal coverage could be financed with a 7% payroll tax, a 2% income tax and current federal and state payments.” Her conclusion holds true today. National health insurance could provide access to health care for every resident of this country while spending no more than we are now. The savings from the greater efficiency of a single payer system like Medicare would pay for the cost of coverage for the 40 million currently uninsured.

Current Spending

Of the approximate \$1.3 trillion dollars spent in 2000 (the most recent year for which data is available), nearly a third was spent on hospital care. Physician services claim 22%, followed by drugs and other products at 13%. Private health insurance pays slightly more than one-third of all personal health expenses, *with 43% of the bill paid by government programs*, primarily Medicare and Medicaid. Out-of-pocket payments by individuals and families (\$694 per capita) account for 17% of all spending. (See figure)

US Personal Health Expenditures by Source of Funds (2000)

Private	\$ Billion	Percent
Health insurance	391	34.6
Out-of-pocket payment	194	17.2
Other private funds	57	5.0
Government		
Medicare	217	19.2
Medicaid	188	16.6
Other	85	7.5
Total	1,130	100.0

When we look at the source of all health spending, we find that premiums and taxes paid by employers account for 26% of all funds, while individuals and families pay 33% through their contributions to insurance premiums, out-of-pocket spending (including insurance deductibles and copayments), and Medicare taxes. Government, from general revenues, pays 36% of all expenditures for Medicaid, community health centers, veterans services, and medical research as well as private insurance premiums for government employees. (See figure)

National Health Expenditures by Payer (2000)

	\$ Billion	Percent
Private Business		
Health ins premiums	246	19.6
Workers comp	23	1.8
Medicare contributions	61	4.9
Household		
Contrib. to premiums	126	10.1
Out-of-pocket spending	195	15.5
Medicare contributions	98	7.8
Government		
Private ins. Premiums	71	5.6
Medicaid	207	16.5
Other	171	13.6

A portion of this spending provides care for the uninsured through various forms of “cost shifting.” While the uninsured do not receive the same level of care as their insured counterparts, they do receive a substantial amount of care, much of it from emergency rooms. The cost of bringing the uninsured up to “average use” through a system of universal care will therefore be less than if they currently received no care at all.

A sizable part of current spending goes to the various overhead costs, including claims processing, marketing, and profits, of the for-profit insurance industry. *While the Medicare program has an overhead of 3%, private insurance carriers show overhead costs that range from 16% to as much as 30%.* Eliminating those unnecessary non-medical costs provides much of the savings that

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could be achieved through single payer national health insurance.

California and Rhode Island Cost Studies

A number of studies have now been conducted of the costs and benefits of single payer plans. The most comprehensive was the study conducted by the Lewin Group for the California Health Care Options Project (www.healthcareoptions.ca.gov). Nine different proposals were analyzed, of which three were single payer plans. (See figure). The Lewin study found net savings for each plan, with bulk purchasing and administrative cost savings greater than the increased spending resulting from expanded access to care. When extrapolated to the nation, these findings suggest savings of \$34-40 billion each year. *Only the single payer plans resulted in a decrease in health care costs and complete coverage of the uninsured.* (While the Lewin study predicted net savings of 2-3%, these are probably within the margin of error of such a study; breaking even is probably more realistic.) All the incremental proposals increased costs while covering only a portion of the uninsured.

Summary of Key Provisions of the Three Single-payer Proposals

	Cal-Care	California Single-Payer Plan	California Health Service Plan(CHSP)
Shared Features of Plans			
Coverage	All California residents including undocumented		
Covered Services	Hospital inpatient care; Hospital outpatient care; Emergency room care; Physician services;	Prescription drugs; Durable medical equipment; Mental health; Substance abuse;	Acupuncturists; Chiropractors; Dental care (except orthodontia); and Vision
Expenditure Budgets	Program spending is capped at current levels indexed by the rate of growth in state gross domestic product (GDP)		
Additional Coverage			
Nursing Home (except room and board)	✓	✓	--
Home Health (people with 3+ ADEs only)	✓	✓	--
Eye Glasses	✓	✓	--
Other Alternative Care (herbalists etc)	✓	--	--
Co-payments for Services	• None for primary care • \$25 co-pay for specialist care w/o referral	• \$5.00 per visit • \$5.00 per prescription	None
System-wide Impact on Health Spending (in millions)			
Current System-wide Spending	\$151.8	\$151.8	\$151.8
New Utilization due to Coverage Expansion	\$14.4	\$9.6	\$13.5
Savings in Administration and Bulk Purchasing	(\$18.1)	(\$17.2)	(\$21.0)
Net Change in System-wide Health Spending	(\$3.7)	(\$7.6)	(\$7.5)

Source: Lewin Group estimates using the California version of the Health Benefits Simulation Model (HBSM).

A study of Rhode Island's health care system conducted by the Health Reform Program of Boston University and Solutions for Progress, Inc. found similar results: Utilization costs would rise 12% while savings would amount to 15%, for a net saving of 3.6%, or \$300 million.

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Each of the California proposals varies slightly in its sources of revenue, but

all are based on a payroll tax of between 8% and 10% (See figure). With this financing, the study found that all families with incomes under \$100,000 would spend less than they are now spending on health care. Similarly, businesses which now offer health insurance to their employees would find little change in their health spending, but companies, primarily small firms, not providing health insurance would find their spending increased by more than \$1,000 per employee. These businesses have been the principal opponents of health care reform in the past, and alternative approaches, such as phasing in the business payroll tax, or having a smaller tax for small businesses, should be explored.

Sources and Uses of Funds Under the Single-Payer Programs in 2002 (in billions)

	Cal Care	California Single-Payer Plan	California Health Service Plans
Uses of Funds			
Health Services Expenditures	\$132.3	\$127.2	\$124.8
Capital Acquisition Payment	--	--	\$2.7
Program Administration	\$2.4	\$2.4	\$1.5
Total Uses of Funds	\$134.7	\$129.6	\$129.0
Sources of Funds			
Funding from Current Government Programs	\$65.7 ^{a/}	\$63.9	\$63.9
Payroll Tax	\$61.4	\$52.3	\$64.1
Tobacco Tax (\$1.00 per pack) ^{b/}	\$1.0	\$1.0	\$1.0
Increase Sales Tax (1/4 percent)	\$1.0	--	--
Increase Alcoholic Beverage Tax (800 percent)	\$2.0	--	--
Increase Income Tax	--	\$12.4	--
Tax on Unearned Income	\$3.6	--	--
Total Sources of Funds	\$134.7	\$129.6	\$129.0

National legislation

National proposals use a variety of sources, including existing government revenues, for financing a national health insurance program. HR 1200, the McDermott Bill first introduced in 1993, proposes an increase in income tax rates and several additional taxes on the wealthy. The recently-introduced Conyers Bill, HR 676, relies on a payroll tax; it, too, has additional taxes on the wealthy. The payroll tax (even one without an upper-income cap) is not as progressive as an income tax, but it has the virtue of simplicity: it is easy to compute what anyone's tax would be based on their wages or salary.

General Revenues and Trust funds

The money that would fund a national health insurance plan can be handled in two ways. The new taxes could be added to general federal revenues, and funds for the program could be appropriated annually by Congress (this is the approach taken currently in HR 676). Alternatively, a trust fund could be established to house the money for the national program. This would "protect" the money from being siphoned off for other uses and reduce the dependence on yearly action by Congress, but it is vulnerable to the concern, often-expressed, that the trust fund will "run out." These alternative approaches should be debated further.