Funding HR 676: The Expanded and Improved Medicare for All Act
How we can afford a national single-payer health plan

Gerald Friedman, Ph.D.
Professor
Department of Economics
University of Massachusetts at Amherst

gfriedma@econs.umass.edu

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Funding HR 676: The Expanded and Improved Medicare for All Act

How we can afford a national single-payer health plan

By Gerald Friedman, Ph.D.

July 31, 2013

Executive Summary

The Expanded and Improved Medicare for All Act, HR 676, introduced into the 113th Congress by Rep. John Conyers Jr. and 37 initial co-sponsors, would establish a single authority responsible for paying for medically necessary health care for all residents of the United States.

Under the single-payer system created by HR 676, the U.S. could save an estimated $592 billion annually by slashing the administrative waste associated with the private insurance industry ($476 billion) and reducing pharmaceutical prices to European levels ($116 billion). In 2014, the savings would be enough to cover all 44 million uninsured and upgrade benefits for everyone else. No other plan can achieve this magnitude of savings on health care.

Specifically, the savings from a single-payer plan would be more than enough to fund $343 billion in improvements to the health system such as expanded coverage, improved benefits, enhanced reimbursement of providers serving indigent patients, and the elimination of co-payments and deductibles in 2014. The savings would also fund $51 billion in transition costs such as retraining displaced workers and phasing out investor-owned, for-profit delivery systems.

Health care financing in the U.S. is regressive, weighing heaviest on the poor, the working class, and the sick. With the progressive financing plan outlined for HR 676 (below), 95% of all U.S. households would save money.

HR 676 (Section 211, Appendix 2) specifies a financing plan for single-payer that includes

- Maintaining current federal financing for health care
- Increasing personal income taxes on the top 5% of income earners
- Instituting a modest tax on unearned income
- Instituting a modest and progressive tax on payroll, self-employment
- Instituting a small tax on stock and bond transactions

The following progressive financing plan would meet the specifications of HR 676:

- Existing sources of federal revenues for health care
- Tax of 0.5% on stock trades and 0.01% tax per year to maturity on transactions in bonds, swaps, and trades
- 6% high-income surtax (applies to households with incomes > $225,000)
- 6% tax on unearned income from capital gains, dividends, interest, profits, and rents
- 6% payroll tax on top 60% of income earners (applies to incomes over $53,000, tax paid by employers)
- 3% payroll tax on the bottom 40% of income earners (applies to incomes under $53,000, tax paid by employers)

HR 676 would also establish a system for future cost control using proven-effective methods such as negotiated fees, global budgets, and capital planning. Over time, reduced health cost inflation over the next decade ("bending the cost curve") would save $1.8 trillion, making comprehensive health benefits sustainable for future generations.

Section I: Financing needs for single payer

Regressive and obsolete funding sources to be replaced by progressive taxation

Health expenditures under the existing health care system are projected to total $3.13 trillion in 2014, plus $32 billion in spending by employers for administering employer-based health insurance plans.[1] Health care financing in the U.S. is highly regressive, with low-income households and those dealing with serious illness or injury paying larger shares of their incomes towards health care than high-income and healthy households.

Under HR 676, progressive federal taxes (i.e. taxes that reduce the proportion of income paid by low-income households and those faced with a serious illness for medical care) would replace current regressive, income-invariant sources of health care financing such as spending by businesses and 80% of out-of-pocket spending by individuals.[2]

Progressive federal taxes would also replace regressive and obsolete funding sources including federal, state, and local government spending on private health insurance for government employees, and state and local government spending on Medicaid and other health programs. According to data from the Centers for Medicare and Medicare Services (CMS), these expenditures will total $1,723 billion in 2014. See Table 1.

Current spending on federal government programs to be applied to funding HR 676 amounts to $1,344 billion.[3] This includes federal spending for the Medicare program, the Medicaid program, and the Children's Health Insurance Program. Other funding sources include $47 billion in revenue from new Medicare taxes included in the Affordable Care Act of 2010, and the remaining 20% of out-of-pocket spending by individuals. Together, these funding sources amount to $1,454 billion of spending retained for funding HR 676 in 2014.

Table 1. Regressive and obsolete funding sources to be replaced by progressive taxation (in billions of dollars)

Private business	
Employer contribution to private health insurance premiums	414.2
Workers compensation and worksite health care	35.7
Household	
Employee contribution to private health insurance premiums and individual policy premiums	311.5
Premiums paid by individuals to Medicare Supplementary Medical Insurance	67.4
80% of out-of-pocket health spending	254.2
Other private revenues	167.3
Governments	
Federal	
Employer contribution to private health insurance premiums	34.7
State and Local government	
Employer contribution to private health insurance premiums	158.0
Health program expenditures (including Medicaid)	124.8
Other	155.3
Total current spending to be replaced with progressive financing	$1,722.9

Source: http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf; and http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/sponsors.pdf.

Estimated cost of system improvements and transition costs

A single-payer program would improve the health system in many ways. It would extend coverage to all uninsured Americans.[4] It would reduce barriers to access for the currently insured by eliminating burdensome co-payments, deductibles and other out-of-pocket spending for medical care. It would offer improved benefits by covering services like dental and long-term care. It would eliminate inequity in the treatment of less-affluent patients by paying providers the same fee for each patient regardless of income or employment.[5] These improvements would cost an estimated $343 billion annually.

Transition costs of implementing HR 676 would include the cost of unemployment insurance and retraining of displaced insurance and provider administrative personnel.[6] In addition, the cost of converting investor-owned health care facilities to non-profit status would be incurred and is spread out over 15 years.[7] Including transition costs of $51 billion in the first year, the estimated cost of expanding and improving Medicare is $394 billion. See Table 2.

Section II: Single-payer system savings as a source of financing

Savings on provider administrative overhead and drug prices

For decades, health care costs have risen much faster than income in the United States. As a result, total health care spending has risen from 5% of Gross Domestic Product in 1960 to nearly 18% today. While some of the increase in costs in the United States is due, as in other countries, to improvements in care, innovative technologies and greater longevity, costs have risen much faster in the United States than elsewhere because of the growing administrative burden of our private health insurance system.

Because of the large number of separate insurance programs and the fragmented billing system, American physicians and hospitals incur much greater costs for billing and insurance-related activities than do their foreign counterparts. Compared with doctors in Ontario, Canada, for example, Americans spend nearly four times as much on billing and insurance related

Table 2. Estimated cost of health system improvements and transition costs under HR 676 (in billions of dollars)

Increased utilization	144
Cost of expanded coverage including added government administrative costs	110
Cost of Medicaid rate adjustment	89
Transition cost of unemployment insurance and retraining for displaced workers	31
Transition cost of capital buy-out of private health care facilities	20
Total	$394

Note: The cost of coverage expansion includes overhead on all new coverage under the single payer ($25 billion) as well as $85 billion to cover the estimated 44 million who will be uninsured in 2014. It assumes the uninsured spend 55% as much on health care as the insured and would spend 80% with insurance; the lower spending is based on the age distribution of the uninsured. It is assumed that the ACA would have lowered the share without insurance by 11 million from 2013 to 2014, to 16% of the nonelderly population in 2014.[8] Utilization expansion assumes a 3% increase for most activities with a 20% increase for dental care (currently not provided for many insurance plans), a 20% increase in nursing home care, and a 40% increase in home health care. Current Medicaid physician rates are 34% below those paid under Medicare, and the ACA provides for an increase in rates for primary care to Medicare levels; this adjustment assumes that they will be equalized for all physician services.[9]

Table 3. Savings on provider administrative overhead and pharmaceutical costs (in billions of dollars)

	Health care spending with ACA	Savings rate	Savings w/ H.R. 676
Hospital care	983	9.4%	91.9
Physicians and clinical services	602	10.7%	64.2
Other professional services	84	9.0%	7.6
Dental services	120	9.0%	10.9
Home health care	88	19.2%	17.0
Nursing home care	172	7.0%	12.0
Other personal health care	164	10.7%	17.5
Subtotal savings on provider overhead			221.0
Subtotal savings on pharmaceuticals	309	37.5%	115.8
Total savings on provider overhead and drug costs under HR 676			$336.9

Sources: Administrative savings are the difference between overhead costs in the United States and Canada in 1999 from Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Cost of Health Care Administration in the United States and Canada," New England Journal of Medicine no. 349 (2003); relative drug prices are from McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States," January 2007; projected spending under the ACA in 2014 is from Centers for Medicare and Medicaid Services.

Table 4. Savings on administrative costs of insurers, Medicaid, and employers (in billions of dollars)

Insurer overhead (excluding costs to providers)	197.4
Medicaid overhead	26.0
Employers' costs to manage employer-sponsored health coverage	31.7
Total	$255.1

activities ($83,000 per physician versus $22,000 in Ontario), and nursing staff, including medical assistants, spent 20.6 hours per physician per week interacting with health plans – nearly ten times that of their Ontario counterparts.[9]

In addition to the administrative savings within provider offices, a single payer system could lead to dramatic savings by negotiating reduced prices for pharmaceuticals which cost approximately 60% more in the U.S. than in Europe.[10] See Table 3. Today, Medicare is the only entity in the world excluded from negotiating lower prices on medications for its beneficiaries.

Savings on the administrative costs of private insurers, Medicaid, and employers

In addition to reducing the overhead of providers like doctors and hospitals, eliminating private insurance plans would also generate administrative savings on insurance overhead. Currently, private insurers have a "medical loss ratio" (the share of health care spending going for medical services) of barely 88%. The 12% administrative cost average includes the cost of advertising, enrollment, collecting premiums, paying claims, bureaucratic red-tape designed to discourage the submission of claims, inflated executive compensation, and profit, as well as relatively high administrative cost due to the small scale of many companies. A single-payer system would eliminate most of these costs, raising the share of spending going to providers up to the 98% rate for Medicare. With almost a trillion dollars in premiums paid into private health insurance, lowering the administrative ratio to the Medicare rate would save over $197 billion.[11]

Figure 1. Single-payer system savings from reduced administrative costs and drug prices (in billions of dollars)

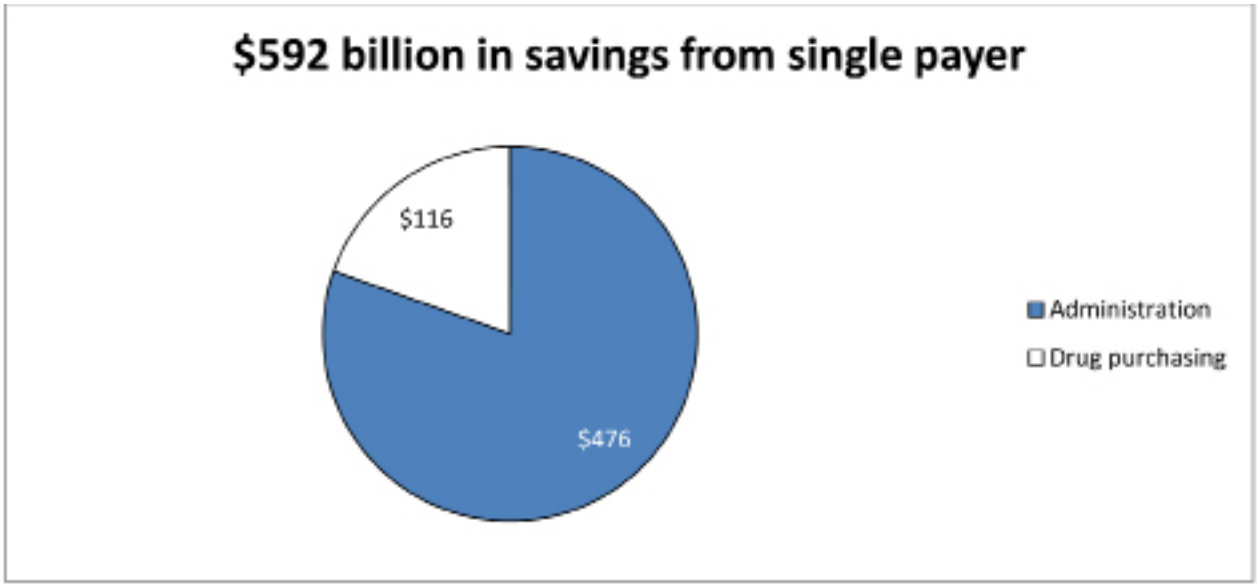


Table 5. Savings on federal tax expenditures for health care (in billions of dollars)

Exclusion of employer contribution for health insurance premiums from income tax	211.5
Exclusion of employer contribution for health insurance premiums from Medicare payroll tax	16.0
Self-employed medical insurance premiums	7.7
Medical Savings Accounts	2.2
Deductibility of medical expenses	11.2
Exclusion of interest on hospital construction bonds	5.5
Special Blue Cross/Blue Shield deduction	0.5
Distributions from retirement plans for premiums for health insurance	0.4
Credit for employee health insurance expenses of small business	4.5
Total federal income tax expenditures	$259.5

Sources: Government Printing Office, Analytical Perspectives, Budget of the United States, 2012, 243. Estimates for 2010 have been adjusted for 2014 at the rate of increase in general health care expenditures 1991-2009 from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/sponsors.pdf.

Further savings of $26 billion would come from the reduction in the administrative expenses of running Medicaid as a joint federal-state means-tested program. Currently, 5.7% of Medicaid expenses go for administration, including the cost of checking eligibility and operating a payment system separate from Medicare and other insurance systems.[12]

In addition, employers will save $32 billion on the direct costs of managing their employer-provided health insurance systems, including the costs of collecting and processing payments as well as consultant charges for choosing an insurance carrier. See Table 4.

Altogether, administrative savings from the single-payer system, on providers' overhead costs, and on administrative expense among insurers, Medicaid, and employers, come to $476 billion in 2014. Adding in the savings on prescription drugs of $116 billion brings the total savings to $592 billion. See Figure 1. Moreover, a single-payer system would slow the growth in health care spending from year to year, greatly reducing the burden of health care costs over the long term.[13]

HR 676 would eliminate the need for federal subsidies for the purchase of private health insurance by business and individuals. Along with deductions for medical savings accounts, medical expenses and some smaller tax breaks associated with the private insurance system, eliminating tax subsidies would save $260 billion (Table 5).

Section III: A progressive funding plan for HR 676

The health care improvements and transition costs of a single-payer system ($394 billion, Table 2), including expanding coverage to 44 million uninsured Americans and upgrading coverage for everyone else, would be funded under HR 676 by $592 billion in savings on administrative costs and reduced pharmaceutical prices. As a result of implementation of HR 676, health spending in the first year would fall by $198 billion to $2,964 billion (Table 6).

Table 6. National Health Expenditures with and without Implementation of HR 676 (in billions of dollars)

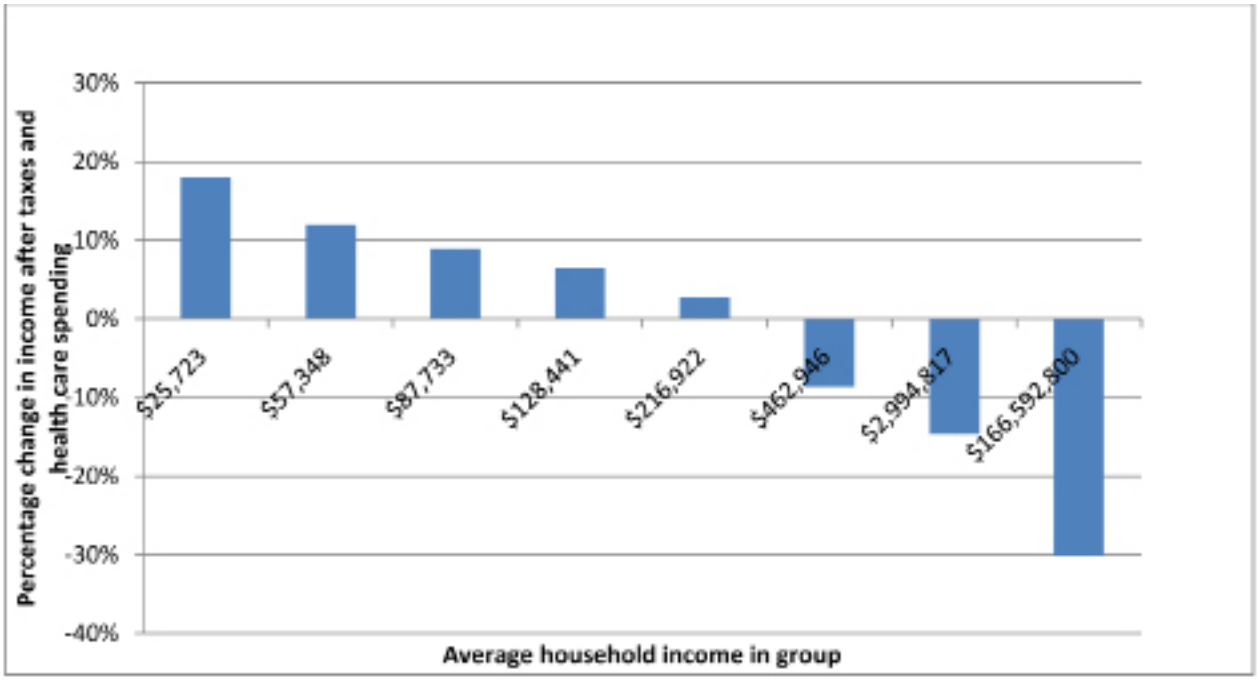
Baseline projected NHE 2014	3,130
Employers' costs to manage health coverage	32
Expenditures without single-payer reform	3,162
Single-payer system improvements and transition costs	394
Single-payer savings on administrative and drug costs	(592)
Expenditures with single-payer reform	$2,964

Table 7. A progressive financing plan for HR 676 that replaces regressive funding sources and improves and expands comprehensive benefits to all (in billions of dollars)

New progressive revenue sources	
Tobin tax of 0.5% on stock trades and 0.01% per year to maturity on transactions in bonds, swaps, and trades.	442
6% Surtax on household incomes over $225,000	279
6% tax on property income from capital gains, dividends, interest, profits,	310
6% payroll tax on top 60% with incomes over $53,000	346
3% payroll tax on bottom 40% with incomes under $53,000	27
Total new progressive sources	1,404
Tax expenditure savings	260
Federal Medicare, Medicaid, and other health spending, and 20% of current out-of-pocket spending (maintained from current system)	1,454
Total Revenues	3,118
Savings for deficit reduction	$154

Sources: Revenue from the Tobin Tax from Dean Baker, et al., "The Potential Revenue from Financial Transactions Taxes." The Baker et al. estimates are for 2011 and I have extrapolated assuming revenue will grow at the same pace as the GDP; this conservative assumption leads to an understatement of revenue. Income distribution is from the updated background tables for Thomas Piketty and Emmanuel Saez, "Income Inequality in the United States."[16] Revenue is calculated by applying the tax rates to the reported income; since Piketty and Saez use IRS income data, I am assuming the same rate of noncompliance as under the current tax law. I have extrapolated from 2006 assuming that all income groups and all income types grew equally with the GDP; this conservative assumption leads to an understatement of revenue.

Figure 2. Change in after-tax household income due to adoption of progressive financing for HR 676: 95% of Americans are better off under a single-payer system



Note: The percentages shown here are the difference between the share of income spent on health care now and the amount that would be spent under the proposed single-payer plan including the taxes proposed to replace the current regressive funding system. The taxes included here are a Tobin tax (described in the text), a 6% surtax on the richest 5% of households, a 6% tax on unearned income (including capital gains, dividends, interest, profits, and rents), a 6% tax on the top 60% of wages and salaries, and a 3% tax on the bottom 40%. The first four bars from the left represent the income of the bottom four quintiles of the population; the next bar (for an average income of $216,922) represents the next 15% (from the 80th to the 95th percentile); the next bar represents the next 4%; the next bar (for an average income of $2,994,817) represents the mean income of the richest 1% of the population; and the final bar (with an average income of $166,592,800) represents the wealthiest 400 American households based on their tax returns.[17] Note that the only groups in the population who would pay more for care are the richest 5%.

With the progressive funding plan outlined in Table 7, regressive and obsolete funding sources would be replaced by progressive taxes, including a new tax on financial transactions (a so-called Tobin Tax[14]), a progressive payroll tax and tax on unearned income, and surtax on high income individuals. Under the plan developed here, revenues would exceed expenditures by $154 billion in the first year, generating funds that could be invested in health professional education or used for deficit reduction.[15]

The proposed taxes would be highly progressive, especially compared with current health care spending which falls most heavily on lower-income households. On average, only 5% of Americans would pay more under this proposal, which would mean savings for Americans with household incomes up to well above $200,000. See Figure 2.

Conclusion: Single payer covers more, costs less than current system for 95% of Americans

This analysis shows that it is possible to reform the U.S. health financing system to make it more efficient and equitable. Universal health care with comprehensive benefits could be achieved under a single-payer system as embodied in HR 676. Improved Medicare for All would cost less for 95% of households and reduce the deficit by $154 billion in the first year.

Progressive financing of HR 676 is possible using a Tobin or "Robin Hood" tax as one of the funding sources. Although the Tobin tax is desirable for a number of reasons, HR 676 single payer may be financed without the Tobin tax if necessary. See Appendix 1.

This analysis is done for one point in time, 2014. Over time, the health care system in the United States has become more expensive both relative to the cost of providing equivalent services in the past and relative to other countries.[18] Under the federal reform law of 2010, it is projected that health care costs will continue to grow, creating growing pressure to cut costs by reducing access and quality of care.

In contrast, HR 676 would establish a system for future cost control using proven-effective methods such as negotiated fees, global budgets, and capital planning. Over the next decade, savings from reduced health inflation ("bending the cost curve") would equal $1.8 trillion. On top of the enormous administrative savings of single payer, the savings from effective cost-control would make it possible to provide universal coverage and comprehensive benefits to future generations[19] at a sustainable cost.

Gerald Friedman is professor, Department of Economics, University of Massachusetts at Amherst. He can be reached at gfriedma@econs.umass.edu.

Appendix 1- Summary Tables of Alternatives Financing Plans for HR 676

With Tobin Tax (transactions or "Robin Hood" tax)

In billions of dollars

Baseline spending	3,130
Adjustments	
Employer costs of administering health insurance system	32
Transition costs	
Costs of retraining displaced workers	31
Costs of buying out capital of for-profit health care companies	20
Added spending for improved health care	
Increased utilization	144
Cost of expanded coverage (including added government administrative costs)	110
Cost of Medicaid rate adjustment	89
Total	3,556
Remaining revenue sources	
Federal Medicare, Medicaid, and other health spending, and 20% of current out-of-pocket spending	1,454
Savings from administrative efficiencies and reduced monopolistic drug pricing	592
Tax expenditure savings	260
Net revenue needs	1,250
New revenue sources	
Tobin tax of 0.5% on stock trades and 0.01% per year to maturity on transactions in bonds, swaps, and trades	442
6% surtax on household incomes over $225,000	279
6% tax on property income from capital gains, dividends, interest,	310
6% payroll tax on top 60% with incomes over $53,000	346
3% payroll tax on bottom 40% with incomes under $53,000	27
Total additional revenues	1,404
Net surplus for deficit reduction	$154

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Remaining revenue sources	
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Savings from administrative efficiencies and reduced monopolistic drug pricing	592
Tax expenditure savings	260
Net revenue needs	1,250
New revenue sources	
8% surtax on household incomes over $225,000	373
8% tax on property income from capital gains, dividends, interest, profits, and	414
8% payroll tax on top 60% with incomes over $53,000	461
4% payroll tax on bottom 40% with incomes under $53,000	41
Total additional revenues	1,289
Net surplus for deficit reduction	$39

Appendix 2: Text of funding section of HR 676 in the 113th Congress

1st Session
H. R. 676
To provide for comprehensive health insurance coverage for all United States residents, improved health care delivery, and for other purposes.

C. 211. OVERVIEW: FUNDING THE MEDICARE FOR ALL PROGRAM.

(a) In General. The Medicare For All Program is to be funded as provided in subsection (c)(1).

(b) Medicare For All Trust Fund. There shall be established a Medicare For All Trust Fund in which funds provided under this section are deposited and from which expenditures under this Act are made.

(c) Funding.

(1) IN GENERAL. There are appropriated to the Medicare For All Trust Fund amounts sufficient to carry out this Act from the following sources:

(A) Existing sources of Federal Government revenues for health care.

(B) Increasing personal income taxes on the top 5 percent income earners.

(C) Instituting a modest and progressive excise tax on payroll and self-employment income.

(D) Instituting a modest tax on unearned income.

(E) Instituting a small tax on stock and bond transactions.

(2) SYSTEM SAVINGS AS A SOURCE OF FINANCING. Funding otherwise required for the Program is reduced as a result of--

(A) vastly reducing paperwork;

(B) requiring a rational bulk procurement of medications under section 205(a); and

(C) improved access to preventive health care.

(3) ADDITIONAL ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL PROGRAM. Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under the Program.

SEC. 212. APPROPRIATIONS FOR EXISTING PROGRAMS.

Notwithstanding any other provision of law, there are hereby transferred and appropriated to carry out this Act, amounts from the Treasury equivalent to the amounts the Secretary estimates would have been appropriated and expended for Federal public health care programs, including funds that would have been appropriated under the Medicare program under title XVIII of the Social Security Act, under the Medicaid program under title XIX of such Act, and under the Children's Health Insurance Program under title XXI of such Act.

Notes

1. Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2011-2021 (Washington, D.C.: Department of Health and Human Services, Center for Medicare and Medicaid Statistics, n.d.) Table 2; employer expenditures administering health insurance plans came to 4.2% of health insurance spending in Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Cost of Health Care Administration in the United States and Canada," New England Journal of Medicine no. 349 (2003): 768–75. This ratio has been applied to employer-based health insurance in 2014.
2. While the largest components of out-of-pocket expenditures, prescription drugs and co-payments and deductibles, will be covered under HR 676, other medically-optional expenditures, such as some dental procedures or luxury eyeglasses, would not be covered, nor would most vitamins and some alternative medical practices. For the breakdown of out-of-pocket spending, see Ann Foster, "Out-of-pocket Health Care Expenditures: a Comparison," Monthly Labor Review (February 2010): 3–20.
3. HR 676 does not incorporate the Indian Health Service for the first five years, or the Veterans Administration for the first ten years (Sec 401). For this study, however, these have been included both on the revenue and the expenditure side.
4. The Congressional Budget Office estimates that there will be 44 million uninsured in 2014 after the Affordable Care Act goes into effect; Congressional Budget Office, "February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," February 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf.
5. Physicians who accept Medicaid patients are paid far less than those who serve other patients. Raising rates would be a transfer to providers who would be paid more for services they are currently performing. It would also improve access by allowing providers to perform services better, by spending more time with each patient; and it would encourage more providers to provide services for less-affluent patients.
6. In Section 303, HR 676 provides for up to two years of unemployment insurance and priority in retraining for "clerical, administrative, and billing personnel in insurance companies, doctors' offices, hospitals, nursing facilities, and other facilities whose jobs are eliminated due to reduced administration." One percent of health spending is set aside for unemployment and retraining annually.
7. In Section 103, HR 676 provides that over a fifteen year period, investor-owners shall be compensated for the actual appraised value of converted facilities used in the delivery of care. A reserve fund of $20 billion annually is created for this purpose.
8. Congressional Budget Office, "February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage."
9. Dante Morra et al., "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers," Health Affairs 30, no. 8 (2011): 1443 –1450, doi:10.1377/hlthaff.2010.0893; Also see, Lawrence P. Casalino et al., "What Does It Cost Physician Practices To Interact With Health Insurance Plans?," Health Affairs 28, no. 4 (July 1, 2009): w533–w543, doi:10.1377/hlthaff.28.4.w533; Woolhandler, Campbell, and Himmelstein, "Cost of Health Care Administration in the United States and Canada"; David Himmelstein, Steffie Woolhandler, and Sidney Wolfe, "Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States, and the District of Columbia, with State-Specific Estimates of Potential Savings," International Journal of Health Services 34, no. 1 (2004): 79–86.
10. McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States," January 2007, http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp; The magnitude of excessive pricing for drugs is indicated by the 80% drop in drug prices when they come out of patent protection and are produced as generics; see Center for Devices and Radiological Health, "About the Center for Drug Evaluation and Research - Generic Competition and Drug Prices," WebContent, accessed December 27, 2012, http://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm129385.htm.
11. No savings have been assumed from reduced fraud despite the great capacity of a single-payer system to reduce or even to eliminate fraudulent billing. Fraudulent billing, including duplicate billing and billing for services not rendered, accounts for between 3% and 10% of health care spending in the United States, including an error rate in federal programs of over 9%. See "Testimony of the National Health Care Anti-Fraud Association" (Harrisburgh, PA., House Insurance Committee, Hourse of Representatives, Commonwealth of Pennsylvania, January 28, 2010), http://www.legis.state.pa.us/cfdocs/legis/TR/transcripts/2010_0017_0014_TSTMNY.pdf; General Accounting Office, Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments (Washington D.C., March 9, 2011), http://www.

gao.gov/new.items/d11409t.pdf; William Hsiao, Steven Kappel, and Jonathan Gruber, "Act 128: Health System Reform Design. Achieving Affordable Universal Health Care in Vermont," January 21, 2011, 34, http://www.leg.state.vt.us/jfo/healthcare/FINAL%20VT%20Draft%20Hsiao%20Report.pdf.

12. The MLR for Medicaid is under 95%, lower than for Medicare because of the more complicated eligibility criteria. April Grady, State Medicaid Program Administration: A Brief Overview (Congressional Research Service, May 14, 2008), http://aging.senate.gov/crs/medicaid3.pdf; ibid.; Earl Hoffman, Barbara Klees, and Catherine Curtis, Title XVIII and Title XIX of the Social Security Act as of November 1, 2005 (Washington D.C.: Centers for Medicare and Medicaid Services, November 2005), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2005.pdf I assume the same administrative savings rate for other government health programs.

13. Since Canada established a single-payer system in 1971, real health care costs have risen by 1.1 percentage points less per year than in the United States. Over half of this difference can be explained by the greater inflation in administrative costs in the United States. Karen Davis et al., Slowing the Growth of U.S. Health Care Expenditures: What Are the Options, Commonwealth Fund Commission on a High Performance Health System (Commonwealth Fund, January 2007), http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUShltcareexpenditureswhatareoptions_989.pdf; Woolhandler S Himmelstein DU, "Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada," Archives of Internal Medicine (October 29, 2012): 1–2, doi:10.1001/2013.jamainternmed.272; McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States."

14. Originally proposed by the Yale economist and Nobel-laureate James Tobin, the United States taxed financial transactions from 1914 till 1966. A financial transactions tax has been endorsed by 11 Eurozone member states where it is scheduled to go into effect in 2014. The National Nurses United is campaigning for such a tax in the United States. Called the "Robin Hood Tax", a proposal for a financial transactions tax has been sponsored in Congress by Representative Keith Ellison in HR 6411; see the discussion at http://robinhoodtax.org/latest/robin-hood-tax-bill-introduced-congress; James Tobin, "A Proposal for International Monetary Reform," Eastern Economic Journal 4, no. 3–4, Eastern Economic Journal (1978): 153–159; Dean Baker et al., The Potential Revenue from Financial Transactions Taxes, Political Economy Research Institute Working Paper Series (Amherst, MA.: Political Economy Research Institute, University of Massachusetts at Amherst, December 2009).

15. Over the next decade, savings from excess revenue, reduced health-care spending because of a slowing in the rate of health-care inflation, and interest savings will produce total deficit reduction of almost $3 trillion.

16. Thomas Piketty and Emmanuel Saez, "Income Inequality in the United States, 1913-1998," The Quarterly Journal of Economics 118, no. 1 (February 1, 2003): 1–39.

17. Internal Revenue Service, The 400 Individual Income Tax Returns Reporting the Highest Adjusted Gross Incomes Each Year, 1992-2007, 2012, http://www.irs.gov/pub/irs-soi/07intop400.pdf.

18. Himmelstein DU, "Cost Control in a Parallel Universe"; Gerald Friedman, "Universal Health Care: Can We Afford Anything Less?," Dollars and Sense, June 29, 2011, http://dollarsandsense.org/archives/2011/0711friedman.html.

19. Health care expenditures for the next decade have been calculated under the assumption that HR 676 is implemented in 2014 and the rate of growth of expenditures slows by 1.1% a year after that. The $1.8 trillion figure is the difference between the annual growth in expenditures projected by the CMS for 2015-24 and the growth projected under these assumptions.

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