

Severing the Tie That Binds

Why a Publicly Funded, Universal Health Care System
Would Be a Boon to U.S. Businesses

Acknowledgments

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Introduction

Americans' dependence on employer-sponsored health insurance arose as an unintended byproduct of World War II economic controls.¹ To circumvent wage caps, businesses began offering health insurance and other fringe benefits to attract workers.² The federal government provided further incentives in 1943 by permitting tax deductions for employer-sponsored health care, and the custom took hold.³

Today, about 90 percent of people in the United States who have private health insurance receive it through employer-group plans, with the other 10 percent purchasing their insurance on the individual market.⁴ Meanwhile, the health care system that employers largely pay for is staggeringly expensive and way out of proportion with the cost of those of other wealthy countries.

Even by a conservative methodology that adjusts for countries' relative wealth (thus taking into account the higher typical compensation in the United States), health care spending in the United States in 2006 was \$643 billion more (out of \$2.1 trillion in total expenditures) than it should have been if other developed countries were used as a guide, according to the McKinsey Global Institute.⁵ More recent data (not corrected for relative wealth) show that the United States spent nearly 1.5 times more on health care as a share of gross domestic product than any other country in the Organization for Economic Co-operation and Development (OECD) in 2011 (the most recent year for which comprehensive data are available.)⁶ On a per capita basis, the United States spent two-and-a-half times as much on health care as the average OECD country that year.⁷

Not surprisingly, businesses view the cost of providing health care benefits as an enormous burden. In each of eight surveys the National Federation of Independent Business has conducted of its members since 1982 on problems facing small businesses, respondents have ranked the "Cost of Health Insurance" number one.⁸ Our system disadvantages

¹ Alex Blumberg and Adam Davidson, *Accidents Of History Created U.S. Health System*, NATIONAL PUBLIC RADIO (Oct. 22, 2009), <http://n.pr/IzNi7q>.

² *Id.*

³ *Id.*

⁴ Roland McDevitt, Jon Gabel, Ryan Lore, Jeremy Pickreign, Heidi Whitmore, and Tina Brust *Group Insurance: A Better Deal For Most People Than Individual Plans*, HEALTH AFFAIRS (Dec. 3, 2009),

⁵ *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More*, MCKINSEY GLOBAL INSTITUTE (2008), <http://bit.ly/1fg8jQP>.

⁶ *OECD Health Data 2013: How Does the United States Compare*, ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (viewed on March 18, 2014), <http://bit.ly/1ePbhhf>.

⁷ *Id.*

⁸ *Small Business Problems & Priorities*, NFIB RESEARCH FOUNDATION (August 2012)

businesses that provide health insurance benefits relative to those that do not because they directly and indirectly end up subsidizing the costs of health care services received by people they do not employ. Further, in a circumstance that often afflicts small businesses, employers that offer health care benefits suffer a cost disadvantage against competitors that do not, although they might realize offsetting advantages through improved ability to attract and retain qualified workers.

Our health care system also imposes a disadvantage on large U.S.-based businesses because their international competitors do not face nearly as significant of health care costs. For instance, as the U.S. automakers' losses mounted amid the recession of 2007, a study revealed that \$1,635 was built into the price of every General Motors vehicle just to pay for health care benefits for GM's employees and retirees. Japan-based Toyota, in contrast, was paying just \$215 per vehicle for current employees' health care and nothing for retirees.⁹

The tie between employment and health insurance causes numerous other distortions in the economy. Perhaps the most prominent of these is a phenomenon known as "job lock." This widely accepted theory posits that employees are reluctant to switch jobs or, especially, to pursue ventures involving self-employment and entrepreneurship out of fear of losing their access to health care. More broadly, job lock may be slowing the rate of economic growth, thereby reducing businesses' pool of potential customers.

A publicly funded, universal health care system in the United States (or, to a lesser extent, within individual states¹⁰) would address many of these problems. By snapping the tie between employment and health insurance, health insurance-based job lock would no longer exist. Meanwhile, the overall costs of health care would likely stabilize due to many factors, chiefly that administrative costs would be reduced and abusive pricing would be policed.

Additionally, although businesses would likely be called upon to pay for some share of health care costs under a universal care system, that cost would likely be reduced for those that currently furnish benefits, and whatever obligations remained for businesses would be distributed more equitably than at present.

⁹ Alex Taylor III, *The Big Three Are Hemorrhaging Money, and Struggling to Stay Competitive With Foreign Rivals*, FORTUNE (Jan. 26, 2007), <http://cnmmon.ie/1nBpUbM>.

¹⁰ See, e.g., TAYLOR LINCOLN, PUBLIC CITIZEN, A ROAD MAP TO 'SINGLE-PAYER': HOW STATES CAN ESCAPE THE CLUTCHES OF THE PRIVATE HEALTH INSURANCE SYSTEM (May 10, 2013), <http://bit.ly/1nKgPec>.

I. A Universal Care System Would End Job Lock and Other Economic Distortions Resulting From Dependence on Employer-Provided Care

Studies have repeatedly shown that employees' dependence on health insurance causes job lock.

A 2010 study by the Rand Institute for Civil Justice found that "business creation rates are substantially lower among wage/salary workers who have employer insurance than among wage/salary workers who have insurance coverage through a spouse or do not have insurance."¹¹ This finding supported the hypothesis that the availability of health care benefits through an employer reduces a person's likelihood of creating a new business.

The Rand study also found that the rate at which individuals create businesses in the months surrounding their 65th birthday was greater than in the months around when individuals turn 55 or 75. (This finding remained intact after correcting for other factors that often accompany a 65th birthday, such as retirement, and the availability of Social Security and pensions.) The study's authors hypothesized that the availability of Medicare freed individuals to start businesses.¹²

Separately, a 2010 study published by the Upjohn Institute examined effects of the Individual Health Coverage Plan (IHCP), a 1993 New Jersey law that guaranteed individuals access to health insurance at community rates, such that every person buying insurance from a given provider would pay the same amount.¹³ The law was intended to reduce people's dependence on employers for access to health insurance.

The study concluded that self-employment in New Jersey increased 14 to 20 percent in the years immediately following the implementation of IHCP. The increases were at the higher end for individuals who were smokers, obese or unmarried. Because these groups of people would otherwise have had a harder time acquiring health insurance, their increased rates of self-employment following IHCP's implementation supported the authors' conclusion that the law reduced job lock.¹⁴

¹¹ Robert W. Fairlie, Kanika Kapur, Susan M. Gates, *Is Employer-Based Health Insurance A Barrier To Entrepreneurship?* RAND INSTITUTE FOR CIVIL JUSTICE (September 2010), at 19-20, <http://bit.ly/1ji7NBp>.

¹² *Id.*, at 46.

¹³ Philip DeCicca, *Health Insurance Availability and Entrepreneurship*, UPJOHN INSTITUTE WORKING PAPER (APRIL 2010), at 6-7, <http://bit.ly/PYnsxd>.

¹⁴ *Id.*

Evidence that health insurance-based job lock is hindering the U.S. economy also can be found by comparing the rates of sole proprietorships and other small business start-ups in the United States with those in developed countries with publicly funded, universal health care systems.

In 2009, John Schmitt and Nathan Lane of the Center for Economic and Policy Research published a study that compared the rates of small business creation and of self-employment in the United States with those in other developed countries. Schmitt and Lane found that United States had the second-lowest rate of self-employed workers compared to 21 other countries in the OECD for which data were available. The United States had the third-lowest rate of manufacturing companies with 20 employers or fewer, and had among the lowest prevalences of small businesses in the high-tech fields of computer-related services and research and development.¹⁵

“One plausible explanation for the consistently higher shares of self-employment and small-business employment in the rest of the world’s rich economies is that all have some form of universal access to health care,” Schmitt and Lane concluded. “The high cost to self-employed workers and small businesses of the private, employer-based health care system in place in the United States may act as a significant deterrent to small start-up companies, an experience not shared by entrepreneurs in countries with universal access to health care.”¹⁶

The Patient Protection and Affordable Care Act (also known as the “ACA” or “Obamacare”) contains certain features intended to mitigate the effects of job lock. Most significantly, it prevents insurers from denying coverage due to preexisting conditions or charging higher premiums based on a health condition.¹⁷

But this is not a complete solution. Individually purchased health care under the ACA is not nearly as affordable for beneficiaries as that which is often offered by employers. A 40 year old in an average state who does not qualify for income-based subsidies could expect to pay about \$3,240 for a “silver” level insurance policy on the individual market. A silver level

¹⁵ John Schmitt and Nathan Lane, *An International Comparison of Small Business Employment*, CENTER FOR ECONOMIC AND POLICY RESEARCH (August 2009), at 1, <http://bit.ly/1e71pcK>.

¹⁶ *Id.*

¹⁷ *Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (Dec. 15, 2011), <http://1.usa.gov/1mZyP6j>.

plan has an actuarial value of 70 percent, meaning the policy holder could expect to pay for about 30 percent of his or her medical costs in addition to premiums.¹⁸

In contrast, employers that offered health care benefits in 2011 paid 82 percent of costs for single-coverage policies with average premiums of \$5,429 and paid 72 percent of family plans with average premiums of \$15,073.¹⁹ This means that employees who received single health care benefits from their employer paid an average of \$951 for benefits that were valued at \$5,429. In contrast, a person buying insurance on the individual market would pay \$3,240 out-of-pocket for a lesser policy. The disparity would be greater for people with family coverage. In 2011, 59 percent of employers with between 3 and 199 employees, and 99 percent of employers with 200 or more employees offered health care benefits.²⁰

Other attempted solutions in the ACA may carry unintended consequences. The ACA was crafted to expand access to care for people with lower incomes by offering eligibility for Medicaid to people with income levels of up to 138 percent of the federal poverty level (FPL). (In 2013, the FPL for the continental United States was \$11,490 for an individual and \$23,550 for a family of four.) The ACA also provided for public subsidies to individuals and families with incomes of up to 400 percent of the FPL.²¹ The subsidies would decrease in relation to income levels.

In February 2014, the Congressional Budget Office (CBO) issued a report concluding that the decreasing publicly funded health care benefits that lower-income workers will receive via the ACA as they climb the income ladder would serve as a modest deterrent to people choosing to work. The CBO concluded that factors relating to the ACA would reduce the number of hours worked by 1.5 to 2 percent from 2017 to 2024, representing a combined decline of 2 million to 2.5 million full-time equivalent workers.²²

Notably, the CBO report said that its predicted reduction would result “almost entirely from a net decline in the amount of labor that workers choose to supply, rather than from a net drop in businesses’ demand for labor.” This means that the reduction would be based on voluntary decisions by workers.

¹⁸ See *Subsidy Calculator: Premium Assistance for Coverage in Exchanges*, HENRY J. KAISER FAMILY FOUNDATION (viewed on March 12, 2014), <http://bit.ly/1a7BRgN>.

¹⁹ *Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (Dec. 15, 2011), at 4, <http://1.usa.gov/1mZyP6j>.

²⁰ *Id.*, at 29, <http://1.usa.gov/1mZyP6j>.

²¹ *The Budget and Economic Outlook, 2014 to 2024, Appendix C: Labor Market Effects of the Affordable Care Act: Updated Estimates*, CONGRESSIONAL BUDGET OFFICE (February 2014), at 117, <http://1.usa.gov/1fLVjCw>.

²² *Id.*

If the reduction in hours worked forecast by the CBO materializes, it may partially owe to workers choosing to reduce their hours because the ACA alleviated their dependence on employer-provided health care. This would appear to be a welcome development for all concerned.

But any degree to which the law discourages individuals from working in order to retain access to Medicaid or health care subsidies—in essence, a manifestation of reverse job lock—would constitute an undesirable, unintended consequence. A publicly funded universal health care system would avoid this pitfall. Individuals would have access to health care because of their membership in society, not due to the size of their incomes.

II. A Universal Care System Would Reduce Overall Health Care Costs Versus Current Trajectory

Implementing a publicly funded universal health care system should reduce the trajectory of projected health care cost increases and, possibly, reduce costs altogether. Even if employers' share of health care costs remained constant, policies that succeeded in "bending the cost curve" would still represent a significant boon to business.

A universal health care system should have a dampening effect on costs for two chief reasons: Administrative costs should decline; and costs for procedures and prescriptions should rise less rapidly and, in some cases, decline. These savings would largely, if not entirely, pay for greatly increased access to care.

A. Potential Administrative Savings

The question of how much is spent on administrative functions in health care has been extensively studied, yet is a frequent source of controversy among pundits and partisans. Much of the controversy likely stems from competing and often poorly understood definitions of what constitutes administrative costs. For instance, some estimates are limited solely to costs experienced by a single segment of the market, such as claims processors, while others define administrative functions much more broadly. Meanwhile, the activities that are categorized as administrative vary from study to study. These discrepancies sometimes foster comparisons purporting to show dramatic differences in administrative costs between systems or countries that do not provide any meaningful insight.²³

²³ Ezra Klein made the broad points enumerated in this paragraph in 2009. See Ezra Klein, *Administrative Costs in Health Care: A Primer*, THE WASHINGTON POST (July 7, 2009), <http://wapo.st/1j4xPML>.

But when one untangles the research on this broad subject and compares like categories, a fairly consistent picture emerges. For instance, multiple studies have determined that physician practices spent between 10 and 15 percent of their revenue on billing and insurance matters. Meanwhile, several studies have estimated overhead to consume between 10 and 12 percent of insurance premiums. (The administrative costs of self-insured plans are lower, according to one study.) Given that health care costs in the United States were about \$2.8 trillion in 2012, these findings lead to an undeniable conclusion that costs are enormous for billing and insurance related matters, the areas most likely to be mitigated by a universal care system.²⁴

In fairness, not all reductions in administrative spending would necessarily correlate with net savings. Some administrative spending, even on billing and insurance related matters, serves a beneficial purpose, such as policing against fraud.

Still, comparisons illustrate that the United States spends much more than other countries on administrative functions, particularly those involving billing and claims processing. Given that these other countries have significantly lower total health care costs than the United States, it seems logical to conclude that they have managed to expend less on administrative functions without succumbing to rampant fraud.

Likewise, comparisons between private and public payers within the United States indicate that savings on the insurance/payer segment of the equation would be achieved by switching entirely to a publicly funded system. These are among the reasons that the United States could reduce administrative costs by switching to a public system:

1. Data show that the share of costs that health care plans devote to administration is inversely proportional to the size of the plans. Due to economies of scale and other factors, plans insuring many people tend to spend less per beneficiary on administrative functions than those insuring fewer people.²⁵ Any publicly funded universal care plan would be extremely large compared to privately underwritten plans that currently exist.

²⁴ *National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2012*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (viewed on March 18, 2014), <http://go.cms.gov/1fhvt7k>.

²⁵ See, e.g., Ezra Klein, *Administrative Costs in Health Care: A Primer*, THE WASHINGTON POST (July 7, 2009), <http://wapo.st/1j4xPML>.

2. Under a public system, resources would not be diverted to pay for insurance companies' profits and marketing expenses. Payers and providers, meanwhile, would spend significantly less, if any, time negotiating over rates.²⁶
3. A publicly funded, universal care system would entail a tremendous reduction in the number of payers with which health care providers would be required to interact. This would significantly reduce providers' administrative costs by streamlining bill submission processes and reducing the resources that providers have to expend navigating the nuances of different insurers' benefits and policies. Thus, even if the administrative costs of *payers* remained the same, a public system would undoubtedly save money by reducing administrative costs incurred by *providers*. [See Table 1 for a summary of findings on administrative costs.]

Table 1: Summary of Research Findings on Health Care Administrative Costs

Study	Type of Cost Assessed	Finding
Kahn et al., Health Affairs (2005)	Administrative costs of physicians' offices, with breakout for "Billing and Insurance Related" (BIR) matters	Total administrative costs are 20-27% of revenue; BIR costs are 12.4-14.5% of revenue.
Kahn et al., Health Affairs (2005)	Administrative costs of hospitals, with breakout for "Billing and Insurance Related" matters	Overall administrative costs are 20.9% of revenue; BIR costs are 6.6-10.8% of revenue, depending on methodology to calculate.
Kahn et al., Health Affairs (2005)	Administrative costs for health insurance with breakout for "Billing and Insurance Related" matters	Overall administrative costs are 9.9% of revenue; BIR costs are 8.4% of revenue.
Casalino et al. Health Affairs (2009)	Time and related costs for physicians to interact with insurance companies	Physicians spend an average of 3 hours weekly interacting with insurance companies at a national cost of \$23 billion to \$31 billion annually.
Sakowski et al., Health Affairs (2009)	Time and related costs for physician practices to interact with insurance companies	Physician practices devote two-thirds of a full-time employee per physician solely to work on billing and insurance matters. BIR costs are \$85,276 annually per physician, equaling 10 percent of revenue.
Morra et al., Health Affairs (2011)	Time and related costs for physician practices to interact with insurance companies	Physician practices in the United States spend \$82,975 per physician interacting with insurance companies, compared with \$22,205 for practices on Ontario, Canada.
Vt. Dept. of Banking, Insurance, Securities and Health Care Administration (2009)	Overhead costs of health insurers in Vt.	Administrative cost for risk-bearing health insurers in Vermont ranged from 10.2 to 13% premiums; costs for employer-funded (or self-insured) plans ranged from 7.1 to 7.3%.
Sara Collins et al., Commonwealth Fund (2009)	Overhead costs of health insurers in the United States compared to other developed countries	Overhead costs accounted for 12.2% of private health insurance company expenditures and 6.1% of public payer expenditures. All told, U.S.

²⁶ Sara R. Collins, Rachel Nuzum, Sheila D. Rustgi, Stephanie Mika, Cathy Schoen, and Karen Davis, *How Health Care Reform Can Lower the Costs of Insurance Administration*, COMMONWEALTH FUND (2009), at 1, <http://bit.ly/1qwgLzY>.

Study	Type of Cost Assessed	Finding
McKinsey Global Institute (2008)	Administrative health care costs in the United States versus other developed countries	health insurance overhead costs equaled \$155.7 billion in 2007. This equaled 7.5% of overall U.S. health care costs, compared to an average of 4% among 10 other OECD countries. Health insurance and administration cost \$145 billion in the United States in 2006, \$91 billion more than would be expected if U.S. health care spending practices were in sync with other developed countries.
Kahn, presentation to Institute of Medicine (2009)	Summarization of research findings for billing and insurance related costs for physician practices, hospitals and insurance companies, with extrapolated estimate for BIR costs for other types of providers.	The upper bound, overall costs to the national U.S. health care system in 2009 for billing and insurance-related functions was \$361 billion. Based on estimates published by the Centers for Medicare and Medicaid Services, that would equal about 14 percent of national health care costs.
Woolhandler et al., New England Journal of Medicine (2003)	Health care administrative costs writ large, United States v. Canada	Overall administrative costs in the United States accounted for 31% of overall U.S. health care spending in 1999 compared to 16.7% in Canada.

Estimates on Providers' Administrative Costs

- In a study published in *Health Affairs* in 2005, James Kahn et al. measured the administrative costs of private insurers, physicians' offices and hospitals in the American West, then estimated the portion of each category's administrative costs that was devoted to billing and insurance (BIR) functions. Kahn et al. determined that administrative costs for physicians' offices ranged from 20.1 to 26.7 percent of revenue (depending on type of practice), and that BIR functions cost between 12.4 and 14.5 percent of revenue.²⁷ They concluded that hospitals' administrative costs averaged 20.9 percent of revenue, and that hospitals' BIR functions cost somewhere between 6.6 and 10.8 percent of revenue, depending how the billing share of certain multipurpose functions was apportioned.²⁸
- A 2009 study published in *Health Affairs* by Casalino et al. concluded that physicians in the United States spend an average of three hours weekly interacting with health plans at a cost of \$23 billion to \$31 billion a year.²⁹ But physician time is a relatively small portion of practices' spending on billing matters. A separate 2009 study by

²⁷ James G. Kahn, Richard Kronick, Mary Kreger and David N. Gans, *The Cost of Health Insurance Administration In California: Estimates For Insurers, Physicians, and Hospitals*, HEALTH AFFAIRS, (November/December 2005), at 1633.

²⁸ *Id.*, at 1634.

²⁹ Lawrence P. Casalino, Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra, Theodore Karrison, and Wendy Levinson, *What Does It Cost Physician Practices to Interact With Health Insurance Plans? A New Way of Looking at Administrative Costs—One Key Point of Comparison In Debating Public and Private Health Reform Approaches*, HEALTH AFFAIRS (May 14, 2009), at 1.

Sakowski et al., also published in *Health Affairs*, concluded that physician practices on average devote two-thirds of a full-time employee per physician solely to working on billing and insurance matters. The researchers concluded that the cost to practices, including physicians' time, to interact with insurance companies was \$85,276 annually per physician, or 10 percent of revenue.³⁰ A 2011 study published in *Health Affairs* by Morra et al. reached similar results, concluding that office-based physician practices in the United States spend an estimated \$82,975 annually per physician interacting with insurance companies.³¹

- A synthesis of research presented by the aforementioned James Kahn to the Institute of Medicine in 2009 estimated that the BIR portion of physician revenue was \$70 billion per year, or 13 percent of revenue. For hospital care, Kahn estimated BIR costs of \$67 billion. Kahn estimated that if a similar rate could be applied to other categories of providers, such as pharmacies and nursing homes, the total, national BIR costs for all providers was about \$214 billion a year.³²

Estimates on Insurers' Administrative Costs

- In a study published in *Health Affairs* in 2005, referenced above, Kahn et al. determined that private insurers' administrative costs equaled 9.9 percent of premiums. BIR functions made up the majority of such costs, accounting for 8.4 percent of premiums.³³
- A 2009 study by the Vermont Department of Banking, Insurance, Securities and Health Care Administration concluded that the administrative cost for risk-bearing health insurers in Vermont ranged from 10.2 to 13 percent of premiums. Insurer

³⁰ Julie Ann Sakowski, James G. Kahn, Richard G. Kronick, Jeffrey M. Newman, and Harold S. Luft, *Peering Into The Black Box: Billing And Insurance Activities In A Medical Group: Standardizing Benefit Plans and Billing Procedures Might Help Reduce Complexity And Billing/Insurance Costs—But Only if Applied Strictly*, HEALTH AFFAIRS (May 14, 2009), at w544.

³¹ Dante Morra, Sean Nicholson, Wendy Levinson, David N. Gans, Terry Hammons, and Lawrence P. Casalino, *U.S. Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers*, HEALTH AFFAIRS (August 2011), at 1443.

³² PIERRE L. YONG AND LEIGH ANNE OLSEN, THE HEALTHCARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES: WORKSHOP SERIES SUMMARY, INSTITUTE OF MEDICINE ROUNDTABLE ON EVIDENCE-BASED MEDICINE (2010), <http://bit.ly/1jikufz>, at 21.

³³ James G. Kahn, Richard Kronick, Mary Kreger and David N. Gans, *The Cost of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals*, HEALTH AFFAIRS (November/December 2005), at 1632.

administrative costs for employer-funded (or self-insured) plans ranged from 7.1 to 7.3 percent.³⁴

- Writing for the Commonwealth Fund, Sara Collins et al. estimated that U.S. health insurance overhead costs equaled \$155.7 billion in 2007. Of this, \$96.2 billion was for private insurance and \$59.5 billion for publicly administered programs. Collins et al. found that administrative costs represent 12.2 percent of private health insurance expenditures, compared with 6.1 percent of public program expenditures.³⁵

Collins et al. also found striking disparities in the administrative costs based on the size of the entity insured. Administrative costs ranged from 5 to 15 percent for group plans for employers with more than 50 employees; 15 to 25 percent for companies with fewer than 50 employees; and up to 40 percent for the individual market. The cost for brokers, alone, in the small-group market, accounted for 4 to 11 percent of premiums, they reported.³⁶

- Writing in the *New England Journal of Medicine* in 2003, Steffie Woolhandler, et al., estimated that overhead accounted for 11.7 percent of private insurance costs in 1999,³⁷ compared with 3.6 percent for Medicare and 6.8 percent for Medicaid.³⁸

Estimates on Employers' Administrative Costs

Though smaller than the administrative cost for providers and insurers, employers also bear substantial expenses to provide health care benefits.

- The 2003 study by Woolhandler et al., referenced above, concluded that employers spent \$15.9 billion on benefits administration and health care benefits consultants in 1999.³⁹ To put that in perspective, employer administrative costs amounted to 22

³⁴ *Health Plan Administrative Cost Report to The House Committee On Health Care, The Senate Committee on Health And Welfare, and the Health Care Reform Commission*, DEPARTMENT OF BANKING, INSURANCE, SECURITIES & HEALTH CARE ADMINISTRATION (December 2009), at 6, <http://bit.ly/1gixxya>.

³⁵ Sara R. Collins, Rachel Nuzum, Sheila D. Rustgi, Stephanie Mika, Cathy Schoen, and Karen Davis, *How Health Care Reform Can Lower the Costs of Insurance Administration*, COMMONWEALTH FUND (2009), <http://bit.ly/1qwgLzY>, at 3.

³⁶ *Id.*

³⁷ Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 THE NEW ENGLAND JOURNAL OF MEDICINE 768, 771 (Aug. 21, 2003), <http://bit.ly/K3Osw>.

³⁸ *Id.*

³⁹ *Id.*

percent of Woolhandler et al.'s estimate of the total administrative costs paid by health insurance companies.⁴⁰

Estimates on Total Administrative Health Care Costs

- In his presentation to the Institute of Medicine, cited above, Kahn estimated the national, upper bound cost for billing and insurance related costs for providers and insurers at \$361 billion in 2009.⁴¹ The Centers for Medicare and Medicaid Services estimated that national health care costs in 2009 were \$2.5 trillion.⁴² Therefore, Kahn's estimate would yield a conclusion that billing and insurance functions consumed up to 14 percent of national health care costs.
- In their 2003, paper, Woolhandler et al. generated an estimate the for all administrative health care related functions (including, and in addition to, billing functions) for which they were able obtain data. They estimated that total administrative costs accounted for 31 percent (\$294.3 billion) of U.S. health care spending in 1999.⁴³

Comparisons Between the United States and Other Countries and Between Public and Private Systems in the United States

- The aforementioned 2011 study by Morra et al. in *Health Affairs* concluding that physicians' practices in the United States spent \$82,975 per physician interacting with insurance companies also estimated such costs for practices in Ontario, Canada, where a single-payer system finances many health care services. The authors concluded that Ontario practices spent just \$22,205 per physician interacting with insurance companies, or just greater than one-fourth as much as in the United States.⁴⁴ The Canadian figure was adjusted upward to account for the reduced purchasing power in Canada; otherwise, the discrepancy would have been slightly greater.

⁴⁰ *Id.*

⁴¹ PIERRE L. YONG AND LEIGHANNE OLSEN, THE HEALTHCARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES: WORKSHOP SERIES SUMMARY, INSTITUTE OF MEDICINE ROUNDTABLE ON EVIDENCE-BASED MEDICINE (2010), at 21.

⁴² *National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2012*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (viewed on March 18, 2014), <http://go.cms.gov/1fhvt7k>.

⁴³ Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 THE NEW ENGLAND JOURNAL OF MEDICINE 768 (Aug. 21, 2003), <http://bit.ly/K30sw>.

⁴⁴ Dante Morra, Sean Nicholson, Wendy Levinson, David N. Gans, Terry Hammons, and Lawrence P. Casalino, *U.S. Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers*, HEALTH AFFAIRS (August 2011), at 1443.

The researchers attributed the difference to the multitude of insurance products that U.S. physicians must deal with, the disparities in rules for those products, and requirements for physicians to receive pre-authorization to render care. The researchers concluded that if physician practices in the United States spent the same amount of time on billing issues as those in Canada, the United States would save \$27.6 billion annually. The researchers concluded that such savings would be greater if hospital-based practices were included in their study.⁴⁵

- The aforementioned study by Collins et al., which estimated that U.S. private health insurance overhead costs equal 12.2 percent of premiums, concluded that U.S. costs were higher as a percentage of national health care costs than in any of 10 other countries in the OECD that they analyzed. Insurance overhead costs accounted for about 7.5 percent of health care spending in the United States by their numbers. In contrast, payers' overhead costs within the 10 other OECD countries averaged just 4 percent. The other countries' totals ranged from 1.9 percent (Finland) to 6.9 percent (France).⁴⁶
- A December 2008 accounting of U.S. health care costs conducted by McKinsey Global Institute concluded that health administration and insurance accounted for costs of \$145 billion in 2006. This figure appears from context in the report to include only costs experienced by insurers and other payers, not providers. The study's authors determined that administration and insurance costs were \$91 billion higher than would be expected if U.S. proportions paralleled other countries' spending after adjusting for relative levels of wealth. Of the \$91 billion in excess spending, \$30 billion consisted of private insurers' profits and taxes.⁴⁷

"A multi-payer system (and a multistate regulated system) creates extra costs and inefficiencies in the form of redundant marketing, underwriting, and management overhead that other OECD countries, which have less fragmented systems, bear to a lesser extent," the McKinsey authors wrote.⁴⁸

⁴⁵ *Id.*, at 1445.

⁴⁶ Sara R. Collins, Rachel Nuzum, Sheila D. Rustgi, Stephanie Mika, Cathy Schoen, and Karen Davis, *How Health Care Reform Can Lower the Costs of Insurance Administration*, COMMONWEALTH FUND (2009), <http://bit.ly/1qwgLzY>, at 2.

⁴⁷ *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More*, MCKINSEY GLOBAL INSTITUTE (2008), at 14, <http://bit.ly/1fg8jQP>.

⁴⁸ *Id.*, at 21, <http://bit.ly/1fg8jQP>.

- Woolhandler et al. (2003) estimated total administrative costs in Canada to equal 16.7 percent of national health care costs, compared with 31 percent in the United States.⁴⁹

B. Potential Savings in the Costs for Pharmaceuticals and Procedures

Another major reason health care spending in the United States exceeds that of other developed countries is that pharmaceuticals and procedures cost much more here than elsewhere.

Pharmaceuticals

Excess spending on pharmaceuticals was responsible for increasing U.S. health care costs relative to those of other developed countries by \$98 billion, according to McKinsey's analysis.⁵⁰ The cost of the average drug is 50 percent higher in the United States than in five European Union countries that the authors surveyed.⁵¹ Also, U.S. consumers use a more expensive mix of drugs. As a result of these factors, the average drug consumed in the United States costs 218 percent as much as the average drug in the EU countries studied.⁵²

Procedures

Procedures also cost dramatically more in the United States than in other developed countries. Table 2 compares costs for some commonly used medical procedures and prescription drugs in the United States with those in France, which the World Health Organization in 2000 ranked as having the best health care services in the world.⁵³

⁴⁹ Steffie Woolhandler, Terry Campbell and David U. Himmelstein, *Costs of Health Care Administration in the United States and Canada*, 349 THE NEW ENGLAND JOURNAL OF MEDICINE 768 (Aug. 21, 2003), <http://bit.ly/K3Osw>.

⁵⁰ *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More*, MCKINSEY GLOBAL INSTITUTE (2008), at 14, <http://bit.ly/1fg8jQP>.

⁵¹ The countries included were the United Kingdom, Germany, Italy, France and Spain.

⁵² *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More*, MCKINSEY GLOBAL INSTITUTE (2008), at 65, <http://bit.ly/1fg8jQP>.

⁵³ IMPROVING PERFORMANCE, WORLD HEALTH ORGANIZATION (2000), at 153.

Table 2: Comparison of Costs for Selected Procedures and Drugs, United States v. France

	United States	France	Pct. Difference U.S. v. France
Angiogram	\$914	\$264	+246.2%
CT scan, abdomen	\$630	\$183	+244.3%
CT scan, head	\$566	\$183	+209.3%
CT scan, pelvis	\$567	\$183	+209.8%
MRI	\$1,121	\$363	+208.8%
Total hosp. & phys. cost: appendectomy	\$13,851	\$4,463	+210.4%
Total hosp. & phys. cost: normal delivery	\$9,775	\$3,541	+176.1%
Cost of hospital per day	\$4,287	\$853	+402.6%
Drugs: Nasonex	\$108	\$17	+535.3%
Drugs: Lipitor	\$124	\$48	+158.3%
Drugs: Nexium	\$373	\$30	+1,143.3%

Source: International Federation of Health Plans. <http://bit.ly/J0rQYi>

The higher costs for procedures are in part due to higher physician pay in the United States. Physician pay, even after correcting for the greater wealth in the United States, raised the U.S. health care bill in 2006 by \$64 billion relative to other developed countries, McKinsey's authors concluded.

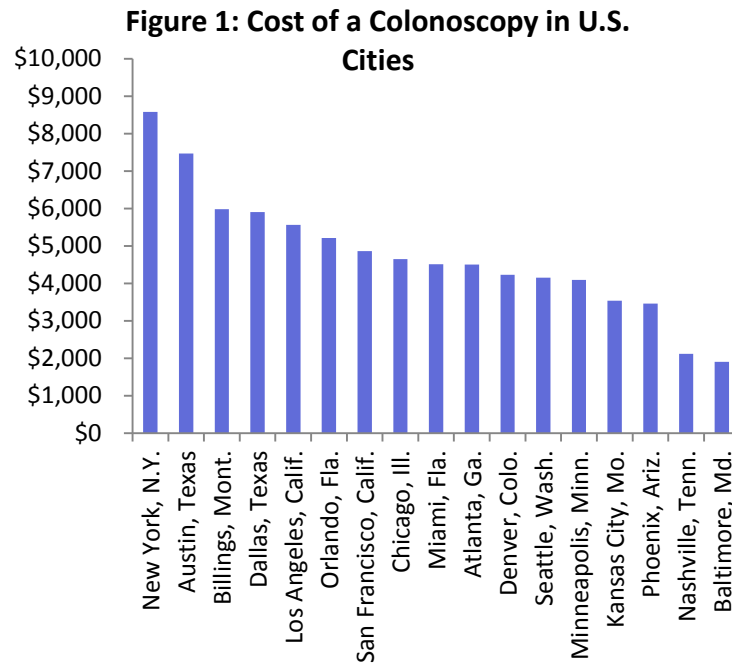
For various reasons, creation of a universal health care system would not realistically bring U.S. prices into line with other developed countries. But through enhanced transparency and the creation of governmental price-setting authority, and institution of annual spending caps for hospitals, a publicly funded system likely would reduce the trajectory of price increases and achieve some actual cost reductions.

Savings from a more regulated system could come from ending practices that are abusive, even by the generous payment standards that prevail in the United States. For example, *The New York Times* reported in June 2013 on the cost of a colonoscopy in 18 U.S. cities.⁵⁴ Prices ranged from \$1,908 in Baltimore to \$8,577 in New York City. Even accounting for disparities in the cost-of-living in New York and Baltimore, it is implausible that a procedure could be fairly priced at \$1,908 in one East Coast city and at \$8,577 in another. Other data further discredit any cost-of-living explanation. At \$4,849 and \$5,850, respectively, San Francisco and Los Angeles providers offered the service for less than it was available in Austin, Texas (\$7,471), where the cost of living is significantly less.⁵⁵ The extent of these disparities strongly suggests the existence of excessive profit-taking or

⁵⁴ Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures*, THE NEW YORK TIMES (June 1, 2013), <http://nyti.ms/1bV5f6d>.

⁵⁵ See, *Cost of Living: How Far Will My Salary Go in Another City?* CNN (viewed on April 1, 2014), <http://cnnmon.ie/1jUS9AB>.

profound inefficiencies.⁵⁶ A more regulated system would expose and police such anomalies. [See Figure 1]



Source: The New York Times (2013), citing analysis by Health Care Blue Book

Separately, *The New York Times* reported in August 2013 on markups of saline solution, which is administered intravenously to replace lost fluids. A one liter bag of saline solution cost providers between 46 cents and \$1.07 in recent years. But patients are sometimes charged up to a hundred times as much for the fluid that is administered to them. For instance, the article reported on an instance in which a patient was charged \$91 for saline solution that cost the hospital 86 cents and another in which a patient was charged “\$546 for six liters of saline that cost the hospital \$5.16.” In the example of the patient who was charged \$91 for 86 cents of solution, a hospital spokeswoman said the fee included “not only the cost of the solution but a variety of related services and processes.” But the patient was charged separately for related services, including “\$127 for administering the IV and \$893 for emergency-room services.” Most of the fees in the cases recounted were covered by private insurance or Medicaid. The reporter was unable to obtain detailed information explaining how the overall saline-related charges were determined, as spokespeople for both public and private entities said that such information was protected

⁵⁶ Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures*, THE NEW YORK TIMES (June 1, 2013), <http://nyti.ms/1bV5f6d>.

by confidential, contractual agreements.⁵⁷ It is highly doubtful that saline solution would continue to be marked up 100 times under a universal care system, and if it were, providers would not be permitted to keep the reasons secret.

Regulated Cost Schedules and Global Budgeting

A window of insight into the potential savings that could be achieved with regulated, standardized cost schedules is provided by the example of cost trends in Maryland, home to the lowest-cost colonoscopy reported in the *Times* article above. Since 1977, Maryland has been granted an exemption by the federal government that allows the state to mandate comparable hospital payment rates for care received by all patients, including those covered by Medicare and Medicaid.⁵⁸ Nationally, private insurers pay about 125 percent as much as Medicare for the same procedures.⁵⁹ But in Maryland, private insurers' payments are lower than in other states while payments by Medicare and Medicaid are higher.⁶⁰

The system has yielded significant overall savings. In 1976, the average cost of a hospital case in Maryland was 26 percent higher than the national average; in 2007, it was 2 percent below the national average.⁶¹ From 1976 to 2007, hospital spending in Maryland was \$40 billion lower than it would have been if the state's rate setting system had not been implemented, *Health Affairs* reported.⁶² If the nation's health care costs had grown at Maryland's reduced rate over that time period, cumulative national health care savings would have exceeded \$1.8 trillion, according to the *Health Affairs* study.⁶³

In January 2014, the federal government announced a renewal of the Maryland waiver, with new requirements. Under the new program, the state will limit the annual rate of growth of total hospital spending (to 3.58 percent) as well as the costs for specific

⁵⁷ Nina Bernstein, *How to Charge \$546 for Six Liters of Saltwater*, THE NEW YORK TIMES (Aug. 25, 2013), <http://nyti.ms/1kPXHJK>.

⁵⁸ See, e.g., Harold A. Cohen, *Maryland's All-Payer Hospital Payment System* (undated), on Web site of Maryland Health Services Cost Review Commission. Cohen was the original director of the Health Services Cost Review Commission. See Jacques Kelly, *Harold A. Cohen, Chairman of Health Cost Commission; He Was a Renowned Health Care Economist*, THE BALTIMORE SUN (Jan. 13, 2012), <http://bit.ly/1Wm5V8>.

⁵⁹ *Report to the Congress: Medicare Payment Policy*, MEDICARE PAYMENT ADVISORY COMMISSION (March 2013), at xiv, <http://1.usa.gov/PXUTjy>.

⁶⁰ Jim McLaughlin, *Maryland Could Lose Medicare Waiver Without Slowed Spending Growth*, BECKER HOSPITAL REVIEW (Jan. 24, 2013), <http://bit.ly/1hfXrAC>.

⁶¹ Robert Murray, *Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience the State's All-Payer System Has Kept Hospital Cost Growth Well Below The National Trend—And Could Be Replicated Elsewhere*, HEALTH AFFAIRS (September/October 2009), at 1399.

⁶² *Id.*, at 1340.

⁶³ *Id.* Under a modified program, per capita hospital spending for Medicare patients in Maryland was capped at 3.58 percent annually for five years beginning on Jan. 1, 2014. See, *Monitoring the Total Costs of Care*, THE MARYLAND HOSPITAL ASSOCIATION (Jan. 9, 2014), <http://bit.ly/1lalyXc>.

procedures. The system, which is projected to save \$330 million in federal spending, aims to remove the financial incentive to providers to administer care that is not medically warranted.⁶⁴

C. Studies Conclude That Overall Savings Could Be Achieved Through Universal Care

Studies suggest that implementing universal care systems would save money while expanding access to care.

- A 2012 study by the Lewin Group concluded that implementation of a single-payer system in Minnesota according to specifications laid out by advocacy group Growth & Justice would achieve universal coverage while reducing health care spending by \$4.1 billion (or 8.8 percent) compared to what it otherwise would be in 2014.⁶⁵

The study forecast that the single-payer system would result in increased use of health care services costing \$1.5 billion but would realize savings of \$4.7 billion in reduced administrative costs and \$900 million in reduced prescription drug and medical equipment costs due to bulk purchasing. The administrative cost savings include \$2.9 billion for insurers, \$1.5 billion for physicians and \$302 million for hospitals.⁶⁶

The study estimated that statewide health care spending would grow from \$42.1 billion in 2012 to \$75.8 billion in 2023 under the prescribed single-payer system. Under the existing system, they estimated that spending would rise to \$113.6 billion by 2023.⁶⁷

This study is somewhat notable because of the identity of the organization that conducted it. The Lewin Group is a wholly owned subsidiary of United Health Care Group, the largest health insurance company in the United States.⁶⁸ Lewin Group has been accused of having a bias in favor of the insurance industry due to its ownership.⁶⁹ But the Lewin Group's finding that a single-payer system in Minnesota

⁶⁴ Sarah Kliff, *Maryland's Plan to Upend Health Care Spending*, THE WASHINGTON POST (April 2, 2014), <http://wapo.st/1s7oIN1>.

⁶⁵ JOHN SHEILS AND MEGAN COLE, COST AND ECONOMIC IMPACT ANALYSIS OF A SINGLE-PAYER PLAN IN MINNESOTA, FINAL REPORT (PREPARED FOR: GROWTH & JUSTICE), LEWIN GROUP (March 27, 2012), at 3, <http://bit.ly/NxihTg>.

⁶⁶ *Id.*, at 10, <http://bit.ly/NxihTg>.

⁶⁷ *Id.*, at 26, <http://bit.ly/NxihTg>.

⁶⁸ Lewin Group Web site (viewed on March 19, 2014), <http://bit.ly/1iE1ARL>.

⁶⁹ See, e.g., David S. Hilzenrath, *Lewin Group, Insurer-Owned Consulting Firm, Often Cited in Health Reform Debate*, THE WASHINGTON POST (July 23, 2009), <http://wapo.st/1mhINPj>.

would save \$2.9 billion in administrative costs would appear to run against its parent company's interest.

- An analysis conducted for Vermont by the University of Massachusetts Medical School Center for Health Law and Economics projected savings of about \$35 million (out of total health care expenses of \$5.9 billion) in 2017 under a universal care system Vermont's legislature has voted to adopt.⁷⁰ Further, the study forecast that costs under a universal care system would be \$86 million less than under the existing system in 2018 and \$158 million less than projected in 2019. Such lower costs would come despite the new system providing care to many more people, and providing more comprehensive benefits to almost everybody. The study assumed that providers, on average, would be paid 105 percent of Medicare rates for caring for non-Medicare patients.

III. A Universal Care System Would Equalize Businesses' Share of Health Care Costs and Likely Lower Costs for Those That Currently Provide Benefits

Merely reducing the size of the nation's health care bill, at least in comparison to what it would otherwise be in future years, would be a benefit to businesses even if their share of costs remained constant. But a publicly funded universal care system would provide additional advantages by reducing inequities among businesses and, potentially, reducing the overall share of costs of health care services that businesses finance.

A. A Universal Care System Would Stop Penalizing Businesses That Provide Health Insurance

U.S. businesses that furnish health care benefits are shouldering costs that go well beyond providing for their own employees. The health insurance premium paid by U.S. businesses has been characterized as a triple tax.⁷¹

1. First, a portion of premium payments pay for health care for the businesses' employees and their family members.
2. Second, the payments indirectly subsidize Medicaid and, arguably, Medicare. This is because hospitals pad their bills to private insurance companies to compensate for

⁷⁰ UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL CENTER FOR HEALTH LAW AND ECONOMICS AND WAKELY CONSULTING GROUP INC. STATE OF VERMONT HEALTH CARE FINANCING PLAN BEGINNING CALENDAR YEAR 2017 ANALYSIS (Prepared for Vermont Agency of Administration) (Jan. 24, 2013), at viii, <http://bit.ly/17ZmaFz>

⁷¹ Toni Johnson, *Healthcare Costs and U.S. Competitiveness*, COUNCIL ON FOREIGN RELATIONS (March 26, 2012), <http://on.cfr.org/1kPD8L9>.

lower payments received from Medicaid and Medicare. This practice is known as “cost shifting.” (The extent to which cost-shifting is justified to make up for Medicare payments is controversial. Some say Medicare payments cover providers’ costs.⁷²)

3. Third, rates billed to health insurance companies are increased to make up for losses that hospitals sustain for services rendered to uninsured patients.⁷³

Under a universal care system, businesses would continue to bear some costs. But their burden would be more evenly distributed.

B. Inequities Currently Borne by Small Businesses Would Be Reduced in a Universal Care System

The percentage of small businesses that offer health insurance benefits is significantly smaller than for large businesses. While 99 percent of businesses that have 200 or more employees offer health insurance, only 59 percent of those with between 3 and 199 workers do so.⁷⁴ But the small businesses that do offer benefits pay quite a bit more than large businesses. Businesses with 10 to 24 employees pay 10 percent more to purchase the same health insurance benefits than large businesses. Businesses with fewer than 10 employees pay 18 percent more.⁷⁵

The Affordable Care Act called for creation of a program, called the Small Business Health Options Program, or SHOP, to create state-level marketplaces that would sell health insurance to businesses of up to 50 employees initially, and eventually up to 100 employees. But the program has been beset with delays and it is unclear if it will enable small businesses to obtain cheaper health insurance.⁷⁶

The traditional nexus between employment and health care benefits besets small businesses with additional quandaries. For example, the ACA called for businesses with 50

⁷² See, e.g., Steven Brill, *Bitter Pills*, TIME (Feb. 20, 2013). (“ ‘When hospitals say they are losing money on Medicare, my reaction is that Central Florida is overflowing with Medicare patients and all those hospitals are expanding and advertising for Medicare patients,’ says [Jonathan] Blum, deputy administrator of the Centers for Medicare and Medicaid Services. ‘Hospitals don’t lose money when they serve Medicare patients.’ ”)

⁷³ Toni Johnson, *Healthcare Costs and U.S. Competitiveness*, COUNCIL ON FOREIGN RELATIONS (March 26, 2012), <http://on.cfr.org/1kPD8L9>.

⁷⁴ *Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (Dec. 15, 2011), <http://1.usa.gov/1mZyP6j>.

⁷⁵ Claire Martin, *In the Health Law, an Open Door for Entrepreneurs*, THE NEW YORK TIMES (Nov. 23, 2013), <http://nyti.ms/1oQJxHV>.

⁷⁶ *Small Business Insurance Exchanges. States and the Federal Government Have Created New Marketplaces to Help Small Companies Buy Coverage More Easily and Cheaply*, HEALTH AFFAIRS (Feb. 6, 2014) and Sarah Kliff, *Obamacare’s Online SHOP Enrollment Delayed by One Year*, THE WASHINGTON POST (Nov. 27, 2013), <http://wapo.st/1fm88DB>.

or more full-time employees to offer health insurance by 2014 or face fines of up to \$3,000 per employee. Although these rules have been delayed until 2015 for businesses of 100 or more full-time employees and until 2016 for businesses with between 50 and 99 employees, the requirement remains imminent.

Some businesses have claimed that they have cut back their number of full-time employees to avoid being covered by the requirement. These claims may simply amount to highly publicized anecdotes that do not reflect a serious trend. “There’s no big strategic part-time shift,” Scott DeFife, a spokesman for the National Restaurant Association, told National Public Radio in 2013. “In fact, data shows that in the past year average hours per employee [are] going up.” But any extent to which businesses are reducing their hours to avoid the health care requirement would constitute an undesirable consequence of the current law.⁷⁷ A publicly funded, universal care system would eliminate this problem.

An additional inequity facing small businesses concerns those with fewer than 50 employees that choose to provide health insurance benefits. Some businesses, such as those in the low-margin restaurant industry, say they cannot offer health care benefits and remain profitable.⁷⁸ If providing health insurance can spell the difference between a profit and loss, that leaves business owners who feel morally obliged to provide benefits in a bind. A system that required all businesses to make equitable contributions toward society’s health care costs would spare owners of the need to make choices between profits and their employees’ health, and would insulate them against a competitive disadvantage vis a vis competitors who would otherwise not pay for benefits.

C. Costs to Businesses That Currently Offer Health Care Benefits Would Probably Be Reduced Under a Universal Care System

Any funding formula for a universal care system, whether at the state or federal level, likely would include contributions from businesses. But costs to businesses that are already providing health care benefits would probably be smaller than at present.

Consider this example. Vermont in 2011 passed legislation that called for it to create a “universal and unified health system.”⁷⁹ Separately, the state’s legislature hired Harvard School of Public Health Professor William Hsiao to design a plan for a universal health care system. Hsiao subsequently proposed funding the system with a 10 percent payroll tax

⁷⁷ John Ydstie, *Full-Time Vs. Part-Time Workers: Restaurants Weigh Obamacare*, NATIONAL PUBLIC RADIO (July 24, 2013), <http://n.pr/1lCrLbk>.

⁷⁸ *Id.*

⁷⁹ See Vermont Act 48 (2011), <http://bit.ly/Ug01Kz>.

assessed to businesses and 4 percent to individuals. Hsiao's proposal did not prove to be politically palatable in Vermont, in part because of the size of the proposed payroll tax.⁸⁰

But even under that level of a payroll tax, businesses that currently offer health care benefits would likely pay less than they are currently paying. The average annual salary in the United States was about \$42,500 in 2012.⁸¹ If a universal care system were funded in part with a 10 percent payroll tax on employers, businesses would end up paying an average of about \$4,250 per employee, per year. Right now, businesses that provide health care benefits pay an average of \$4,451 on behalf of employees with single-coverage and \$10,852 on behalf of those with family coverage.⁸² Therefore, employers that currently furnish health insurance benefits would pay less (and significantly less for family coverage) if their payments were shifted to a simple 10 percent payroll tax.

Conclusion

A publicly funded, universal health care system would sever the tie between employers and the provision of health care. This would benefit employers in numerous ways. Those that currently provide benefits would likely pay less, and would be spared the administrative costs of furnishing health care benefits. Inequities between employers would be reduced. Perhaps more importantly, employers would benefit from a more fluid economy that should boost economic growth, leaving them with a bigger pool of potential customers.

⁸⁰ See, e.g., Hamilton E. Davis, *Analysis: Can This Man Figure Out How To Fund Single Payer?* VERMONT PUBLIC RADIO (Nov. 26, 2013), <http://bit.ly/OoLTLX>.

⁸¹ *Measures of Central Tendency for Wage Data*, U.S. SOCIAL SECURITY ADMINISTRATION (viewed on March 19, 2014), <http://1.usa.gov/OCBWBH>.

⁸² *Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (Dec. 15, 2011), <http://1.usa.gov/1mZyP6j>.