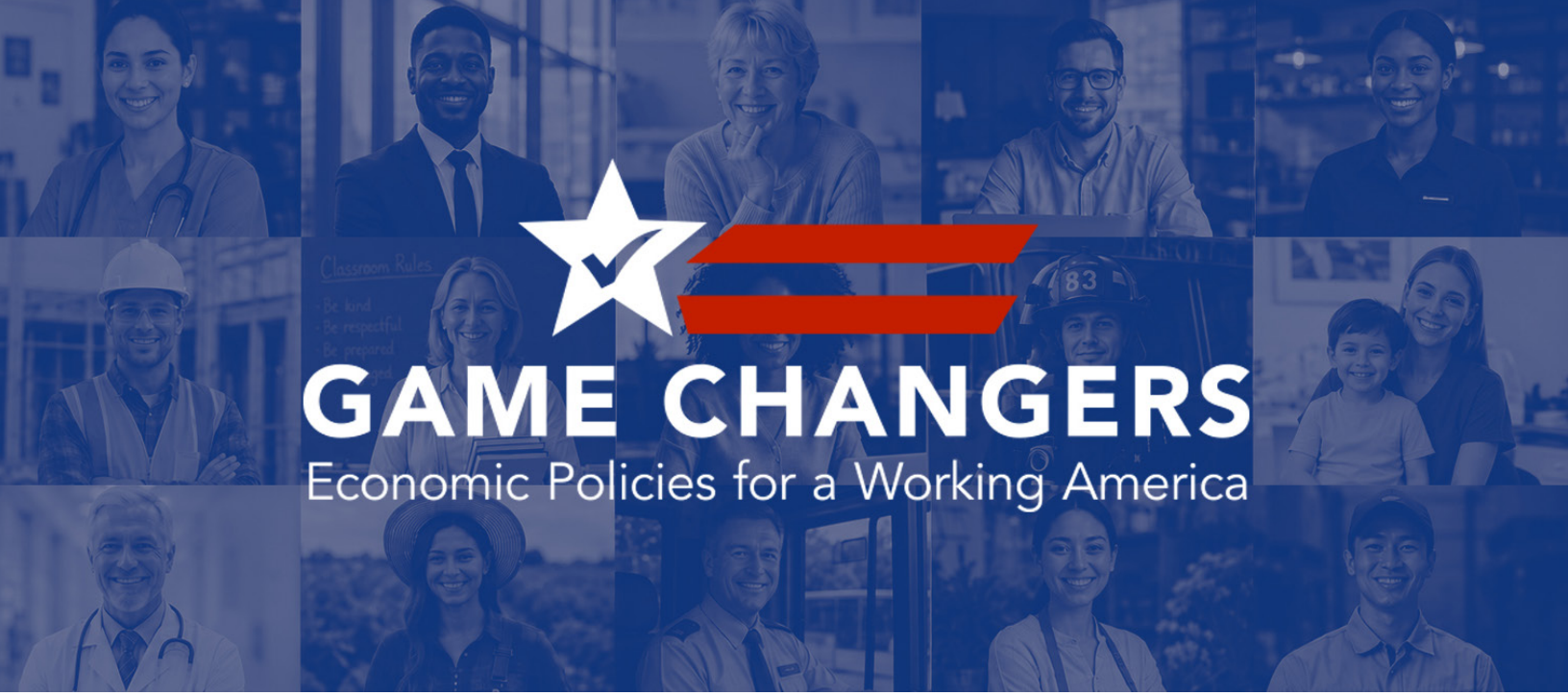

BACKGROUND PAPER / JULY 2026

Medicare for All in the United States:

Moral Imperative and Real Prospects

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MEDICARE FOR ALL IN THE UNITED STATES: Moral Imperative and Real Prospects

By Robert Pollin, Jeannette Wicks-Lim, and Peter Arno

1. Introduction

The United States has a dysfunctional health care system. The U.S. spends about 50 percent more on health care as a share of the economy than other high-income economies, but its population, on average, is much less healthy. A primary factor is that over half of the U.S. population lacks adequate health insurance. By contrast, all other high-income economies provide some version of universal health insurance to its residents. The solution is straightforward: the U.S. should itself adopt a publicly-funded universal health insurance system. Two terms for such systems are widely used in the U.S.: "single-payer" health care and "Medicare for All." We reference both of these terms, along with "universal health insurance" at various points in this paper.

Under a U.S. universal health insurance system, all residents would automatically receive good-quality health care as a basic right, without having to pay premiums, deductibles, co-payments or out-of-pocket expenses. Pope Leo XIV recently expressed the fundamental purpose of universal health insurance as follows: "Universal health coverage is not merely a technical goal to be achieved; it is primarily a moral imperative for societies that wish to call themselves just." [1]

Even while recognizing universal health coverage as, most fundamentally, a moral imperative, it is also true that universal health care can accomplish critical 'technical goals.' In particular, for the U.S. case, the enactment of universal health coverage is capable of delivering large-scale cost savings relative to the current U.S. healthcare system. The major channels through which universal health coverage can achieve cost savings are through lowering administration and prescription drug costs, improving the efficiency of service delivery, reducing fraud and abuse in the payment system, and eliminating the profits of private health insurance companies. These aggregate-level cost savings can then be distributed on an egalitarian basis to households and businesses throughout the economy.

Universal health care could be initially enacted in the U.S. either as a nationwide program or at the level of individual states. Several U.S. states either currently have universal coverage proposals introduced into their state legislatures or have considered such proposals in recent years, including Oregon, Colorado, Illinois, Massachusetts, Minnesota, New Hampshire, Rhode Island, California, and New York.[2]

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[1] https://www.vaticannews.va/en/pope/news/2026-03/pope-leo-xiv-healthcare-for-all-injustice-church-samaritan.html#:~:text=Pope%20Leo%20XIV%20on%20Wednesday,becoming%20a%20cause%20of%20conflict.

[2] https://www.mercer.com/en-us/insights/us-health-news/universal-coverage-debate-heating-up-in-several-states/

Starting with this introductory section, this paper proceeds as follows. In Section 2, we review evidence on the features of the current U.S. healthcare system from which we, along with large numbers of other observers, conclude that the system is indeed dysfunctional.

In Section 3, we consider the prospects for creating a viable single-payer health care system in the U.S., focusing on the case of a state-level project for New York State. We focus on the case of New York State because there is, at present, an active single-payer health care proposal before the New York State Legislature, the New York Health Act. This proposal has already passed the New York State Assembly on five previous occasions, starting in 1992 and most recently in 2018.

In this section, we first estimate the costs of providing good-quality insurance coverage to all New York residents, without requiring any copayments by care recipients. We also estimate the costs of including expanded long-term care support and raising average compensation rates for the state's health care professionals, including physicians and nurses. We then estimate potential sources of savings under New York Health, including reducing administrative costs and prescription drug prices, as well as increasing the efficiency of the service delivery system and reducing fraud and abuse in the payment system. Overall, we estimate that New York Health can deliver good-quality universal coverage while still achieving overall cost savings in the range of 11 percent of overall health consumption expenditures.

Section 4 discusses how to finance New York Health, through a combination of ongoing public sector funding and a new tax structure to substitute for the funds businesses and households now pay to private insurance companies. The tax structure we introduce, by way of illustration, includes five components: payroll taxes; non-payroll taxes on interest, dividends, capital gains and self-employment income; a sales tax on non-necessities; a wealth tax; and a gross receipts tax on businesses. We show that for most categories of households and businesses, their net health care costs will decline under New York Health through this illustrative tax proposal. Moreover, these health care cost savings under New York Health will be significant for most categories of households and businesses.

In section 5, we consider the transition process from New York's current health care system to New York Health. There will be four major sets of issues to tackle in this transition: 1) the overall administrative transition; 2) the impact of the transition on both the incomes of physicians and on the capacity of physicians to meet the increased demand for health care services under universal coverage; 3) the displacement of workers now employed in both the private health insurance and health services industries; and 4) implementing New York Heath under a so-called "wraparound" structure in the event that the federal government does not agree to release federal funds into the state's single-payer system through the existing "waiver" provisions. We explain how each of these challenges can be effectively addressed in mounting a successful transition into the New York Health single-payer system.

Section 6 offers some brief concluding comments.

2. The Dysfunctional U.S. Healthcare System

About 8 percent of the U.S. population today have no health insurance and 48 percent of those with insurance are "underinsured"-- they have coverage but nevertheless forego needed care because what they must pay beyond their insurance coverage is prohibitive. The Affordable Care Act (ACA) was enacted in 2010 under President Obama with the express purpose of dramatically improving health insurance coverage. The ACA did partially succeed. It cut the share of uninsured in half, though the underinsured population share did still rise. Yet even these partial gains under the ACA are now being overturned because the "One Big Beautiful Bill" that passed under President Trump in 2025 includes massive budget cuts to both Medicaid and the ACA. The healthcare budget cuts under Trump are projected to force at least 12 million people to lose coverage.[3]

These budget cuts under Trump need to be understood within the broader context of the dysfunctional U.S. healthcare system. Thus, as of 2024, health care spending consumed fully 17.2 percent of all spending (GDP) in the U.S. economy. This is an increase from 9.8 percent of GDP as of 1985. In other words, health care spending in the U.S. rose by 76 percent as a share of the economy between 1985 – 2024. In today's U.S. economy, the difference between spending 17.2 percent versus 9.8 percent of GDP on health care amounts to $2.2 trillion. Other high-income countries, by contrast, spent an average of 11.2 percent of their overall GDP on health care in 2024. Within the U.S. economy's context, the difference between spending 17.2 percent versus 11.2 percent of GDP on health care totals $1.8 trillion.[4]

Despite spending roughly 50 percent more on health care as a share of GDP than other high-income countries, overall health outcomes in the U.S. are nevertheless much worse than those in all other high-income countries. For example, as of 2023, the U.S. ranked 29th in the world in terms of deaths that could be prevented with medical care, in between the rankings of Costa Rica and Peru. Germany, France, the UK and Canada all had 25 – 50 percent fewer preventable deaths than the U.S.[5]

Evidence on health outcomes that consider only the U.S. case itself are consistent with the findings on relative health outcomes by country. Thus, a 2017 study by Sommers et al. reviewed a range of studies between 2009 – 2017 on the relationship between health insurance coverage and health outcomes. Most of the papers reviewed focused on the impact of the expansion of coverage subsequent to the enactment of the ACA in 2010. Their conclusion from the Sommers et al. survey is as follows:

> The body of evidence summarized here indicates that coverage expansions significantly increase patients' access to care and use of preventive care, primary care, chronic illness treatment, medications and surgery. These increases appear to produce significant, multi-faceted and nuanced benefits to health. Some benefits may manifest in earlier detection of disease, some in better medication, adherence and management of chronic conditions, and some in the psychological well-being borne of knowing one can afford care when one gets sick (2017, pp. 590-591).[6]

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[3] Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package | KFF; GOP 'big beautiful bill' to deal 'shock' to the ACA marketplace

[4] https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/

[5] Mortality rates from preventable causes OECD countries 2023| Statista

[6] N Engl J Med 2017;377:586-593; DOI: 10.1056/NEJMsb1706645; VOL. 377 NO. 6

The conclusions Sommers et al. reached in 2017 were more recently affirmed in a 2025 survey by Levy and Buchmueller that focused on the specific question of how health insurance coverage has impacted mortality rates in the U.S. Levy and Buchmueller conclude as follows:

> The results from these studies provide clear evidence that health insurance coverage improves health. Most of the studies discussed here conduct extensive robustness checks based on alternative outcomes, subpopulations and empirical specifications. The pattern of results is broadly consistent across studies in a way that strengthens this interpretation and provides a fuller understanding of the importance of insurance for health (p. 547).[7]

Lack of universal health insurance coverage also creates heavy financial burdens for a large share of the U.S. population. Consider again the figures on underinsurance rates among the 48 percent of the adult population who are carrying insurance. The 2024 survey by the Commonwealth Fund which reported these underinsurance figures found, more specifically, that this population cohort experienced one of four access problems because of costs: 1) did not fill a prescription; 2) skipped recommended test, treatment, or follow-up; 3) had a medical problem, but did not visit a doctor or clinic; or 4) did not get needed specialist care.[8]

Moreover, within this underinsured population cohort, 40 percent reported that their health problem had gotten worse as a result of delaying or skipping needed care. For those who did absorb the costs of needed medical care, the impact of these costs on their financial security was frequently severe. This becomes clear with respect to people taking on the burdens of medical debt. The same Commonwealth Fund study reports that:

> Medical debt can harm the health and well-being of entire households. More than one-third of those reporting medical debt within their household said it had caused a member to delay or avoid getting needed health care or prescription medications. A similar share said they were forced to cut back on basic necessities like food, heat, or rent, while a quarter said they took on another job or worked more hours. More than three-quarters of people with medical debt said it made them anxious or worried. Medical debt can have lasting financial consequences. Two of five adults reporting debt said they had used up all or part of their savings to pay it off, and 28 percent said they received a lower credit rating because of it.

Overall, this substantial amount of recent literature provides a solid foundation for concluding that the provision of good-quality health insurance coverage for all U.S. residents will provide major benefits in terms of both health outcomes and financial security. At the same time, this does not mean that the universal provision of decent health insurance is the only significant factor in determining health outcomes in the U.S. or elsewhere. Rather, overall health outcomes also depend substantially on the broader set of conditions and life opportunities provided to people in any society.

The transition to a universal healthcare system in the U.S. should encourage more systematic initiatives focused on the social determinants of health, including income inequality and poverty, employment opportunities, education, housing, transportation, nutrition, environmental quality, violence, and the criminal justice system. With respect to overall budgetary priorities, the transition to universal coverage

[7] https://doi.org/10.1146/annurev-publhealth-061022-042335

[8] State of Health Insurance Coverage in U.S.: 2024 Biennial Survey | Commonwealth Fund, p. 7

should similarly encourage greater consideration around rebalancing health expenditures between acute care and prevention. But addressing these broader questions around the social determinants of health is beyond the scope of this study.

3. New York Health: A State-Level Single-Payer Health Care Proposal[9]

Of course, the impact on advancing well-being in the U.S. would be greater if a universal health insurance system were established to cover the entire U.S. population. Proposals for a national Medicare for All system have been introduced multiple times in recent years by Senator Bernie Sanders and Congresswoman Pramila Jayapal. But as a matter of political reality, it is more likely that there will be significant forward movement at the level of some individual states. The experience of Canada offers one important precedent for advancing universal coverage initially at the level of individual states. The Canadian nationwide universal coverage system, Canadian Medicare, was enacted initially in the province of Saskatchewan in 1947 as a hospital insurance plan only, and then spread throughout the rest of the country as a comprehensive coverage structure over the next 20 years (Marchildon 2025).

The proposal in New York State, the New York Health Act, represents one of the more promising prospects among the state-level proposals that are currently under formal consideration. The initial version of the New York Health Act was introduced into the New York State Assembly by Assemblyman Richard Gottfried in 1991. The bill was then passed by the Assembly in 1992. It later passed the Assembly again in 2015, 2016, 2017 and 2018.

Benefit Expansion and Cost Increases

The current status of health care coverage and costs in New York State broadly reflect those for the U.S. overall. Thus, for 2024—the baseline year for our analysis—total health care spending in New York state amounted to about $401 billion.[10] This was equal to about 17 percent of the state's $2.3 trillion in overall GDP that year. Despite this very high level of health care expenditures, about 5 percent of the state's population were not covered at all by health insurance and about 45 percent were underinsured. The first aim of New York Health is therefore to provide universal coverage for all state residents. Of course, this would increase the costs of operating the state's health care system. The extent of that cost increase will have to be estimated.

There are two other areas in which the New York Health Act proposes measures that would entail significant cost increases. One is to significantly improve the extent of long-term services and support in the state, through the existing Consumer-Directed Personal Assistance Program (CDPAP) as well as more generally. These forms of support are designed to assist people who face limitations in areas such as bathing, dressing, feeding oneself, maintaining one's home, shopping for and preparing meals, and taking prescribed medicines.

The other proposal that will require cost increases is to raise average compensation levels for the state's health care professionals, including physicians and nurses. At present, the payment rates provided through Medicare and especially Medicaid are inadequate. They are also much lower than the rates paid

[9] Except where noted, the discussion on New York Health draws from the full-scale study by Pollin, Wicks-Lim and Arno (2026).
[10] The formal health care expenditure category we reference here is "Health Consumption Expenditures. We estimate that the overall level of New York State Health Consumption Expenditures in 2024 was $401.1 billion.

through private insurance arrangements. The aim under New York Health is to provide a more equitable payment structure for all healthcare professionals, and that most of these providers will receive pay increases within this more equitable structure.

The main expansion of benefits—and corresponding cost increases—that New York Health would provide includes the following:

1. Full universal health insurance coverage with no copayments by care recipients. We estimate that, within the existing New York State health care system, this would entail $39.2 billion in increased costs, equal to 9.8 percent of the state's 2024 $401.1 billion health consumption budget.
2. Significantly expanded long-term care support. We estimate this cost increase at $22 billion, equal to 5.5 percent of New York State's 2024 health consumption budget.
3. Average compensation rates for healthcare professionals will increase to 130 percent of current Medicare rates as a benchmark average. Specific compensation rates will be set at decentralized regional and local decision-making levels within a global budgeting framework. We estimate this cost increase at $12.4 billion, equal to 3.1 percent of New York State's 2024 health consumption budget.

We estimate that the overall costs of providing these large-scale benefit increases under New York Health will total about $73.6 billion. This would be an 18.4 percent cost increase relative to the 2024 overall health care expenditure level of $401 billion under New York State's existing health care system. Table 1 summarizes these estimates.

TABLE 1. Sources of Estimated Cost Increases Under New York Health

New York State 2024 Health Consumption Expenditures = $401.1 billion

	Total Cost Increase	**Percentage Cost Increase relative to 2024 Total Health Consumption Expenditures**
Providing Full Universal Insurance Coverage with no Cost Sharing	$39.2 billion	+9.8%
Restructuring Long-Term Care and Expanding Paid Home Health Care Provision	$22.0 billion	+5.5%
Average Healthcare Professional Rates at 130% of Current Medicare Rates	$12.4 billion	+3.1%
TOTALS	**$73.6 BILLION**	**+18.4%**

Sources: See Pollin et al. (2026)

Sources of Cost Savings under New York Health

We estimate that there will be three main sources of cost savings under New York Health. They are:

1. Reducing health insurance administration and private insurance profits;
2. Reducing prescription drug prices; and
3. Service delivery restructuring and payment system redesign.

We consider these in turn.

Reducing health insurance administration and private administration profits

Under the current system, the overall costs—including time, money, and personnel—dedicated to billing and insurance-related (BIR) activities are substantial. It is widely recognized that the existing system operates with widespread inefficiencies and redundancies. The areas of inefficiency and redundancy include: contracting, claims processing, credentialing providers and payment validation. Creating a single payment channel has the potential to achieve large-scale systemwide savings.

Thus, a 2022 Research Brief in *Health Affairs* considers the question of achieving major savings through these channels by surveying 7 research studies that have generated estimates of "health care administrative spending and waste in the U.S." (Health Affairs Forefront, 2022). From this literature, the survey concludes that wasteful administrative spending is at 50 percent or higher of total administrative expenditures. The article concludes that "A review of relevant studies indicates that at least half of total administrative spending is likely ineffective…meaning that it does not contribute to health outcomes in any discernable way."

Further large-scale cost savings can also be achieved under New York Health when the state's Department of Health replaces private insurance companies in the provision of insurance itself. This will mean eliminating private corporate profits as an expenditure category. The savings potential through this channel becomes clear through comparing the total administrative and profit overhead associated with the two existing programs operating under the federal Medicare umbrella. These are the public administration system operating under traditional Medicare and the private insurance system under Medicare Advantage. With Medicare Advantage, private for-profit corporations provide insurance to enrollees. The federal government serves only as the conduit between the private corporations and enrollees.

According to the officially reported federal government figures, administrative overhead for traditional Medicare amounted to an average of 2.0 percent of total system expenditures between 2018 – 2023. Over this same five-year period, administrative overhead plus profits for private corporations under Medicare Advantage averaged 14.3 percent of overall expenditures.

The New York Health program would operate as a fully public non-profit insurance program, equivalent to the federal traditional Medicare program. Thus, as a first approximation, we can estimate that New York Health could operate with administrative costs comparable to those for traditional Medicare, i.e. in the range of 2 percent of overall expenditures.

When we take full account of both of these major areas of potential administrative savings—significantly reducing both administrative inefficiencies and eliminating private corporate profits—and also assigning appropriate weights to these saving sources as a share of New York State's overall health

care budget, we estimate that total savings potential in transitioning from the existing health care system to New York Health will be about 10 percent of overall healthcare spending in the state.

Lowering Prescription Drug Prices

Spending on prescription drugs are a major component of overall healthcare spending in New York State. Total pharmaceutical spending in 2024 amounted to $74.5 billion, equal to 18.6 percent of total health care spending in the state. This includes both retail purchases by health care consumers, totaling to $50.0 billion, and non-retail purchases—i.e. purchases by hospitals, physicians' offices and clinics—amounting to another $24.5 billion.

The New York Health Act bill makes clear that one major channel through which the state's single-payer health care system will achieve large-scale cost savings is through significantly lowering the cost of prescription drugs in the state. The bill states that a primary source of savings under single-payer will be "using the negotiating power of 20 million consumers to achieve lower drug prices," (New York Health Act, 2025, p. 3).

The reason that major cost savings with prescription drug purchases are possible under a single-payer health care system in New York State is that, for the U.S. overall, drug prices are, on average, much higher than in other high-income countries. Thus, a 2024 RAND Corporation study compares prescription drug prices in the U.S. along with those in 33 other high-income countries that are members of the Organization for Economic Cooperation and Development (OECD). This study found that U.S. prices were, on average 64 percent higher than the 33 comparison countries. In comparison with six large individual countries—Canada, France, Germany, Italy, Japan and the United Kingdom—the price differential ranged between 54 percent less in Canada to 71 percent less in Japan.

The reason prescription drug prices are so much lower in these OECD comparison countries is that most of the OECD countries exercise bargaining leverage in negotiating drug prices with private companies. Among European countries, the most common practice is "international reference pricing" (or "external reference pricing"). The European Commission defines external reference pricing as "The practice of using the price(s) of a medicine in one or several countries in order to derive a benchmark or reference price for the purposes of setting or negotiating the price of the product in a given country." (Vogler et al., 2015, p. 5). Other OECD countries, including Japan and Australia, also use this method for regulating drug prices within their national markets.

Another important reference point for achieving significantly lower prescription drug prices within the New York Health structure is within the United States itself, with the operations of the U.S. Department of Veterans Affairs (VA). The VA oversees the country's largest integrated health care system. It includes a national drug plan for more than nine million veterans and provides 144 million prescriptions per year through this system. The VA uses a managed formulary to set prices by weighing the additional therapeutic value of a drug to determine the amount of reimbursement. The VA retains the right to refuse reimbursement of a drug if the drug's low therapeutic value does not justify its price. It is precisely through restricting the number of prescription drugs that it is willing to purchase that the VA is able to increase its bargaining power and obtain lower prices. The VA system does also include a process to request coverage of prescription drugs not found within its formulary. Operating withing this negotiating framework, the VA has consistently purchased prescription drugs at prices that are, on average, 54 percent below market prices in the U.S.

One potential concern in using the VA price-setting system as a comparison point for the U.S. health care system overall is that the VA system serves a limited sample of the U.S. population—i.e., veterans, who are all adults, and are mainly male adults. By contrast, the full U.S. population obviously includes the normal demographic proportions by age and gender of this overall population. As such, it is therefore instructive that the pricing discounts achieved under the VA system in the U.S.—at about 54 percent below market prices—are comparable to the 64 percent average discount achieved by the 33 OECD comparison countries.

Based on the similar range of price discounts between the U.S. VA and the OECD countries, we assume that New York Health could achieve an average discount rate of 50 percent on all prescription drug prices. With total spending on prescription drugs at18.6 percent of all health care spending in New York State, it implies that the potential cost savings would be 9.4 percent of all health care spending through reducing drug prices by an average of 50 percent.[11]

Achieving this level of prescription drug cost savings through New York Health would represent a dramatic advance relative to the programs have been enacted most recently under both the Biden and Trump administrations. Neither the Biden nor Trump programs are capable of achieving anything more than modest cost reductions for a limited number of prescription drugs.[12]

Service Delivery Restructuring and Payment-System Design

The New York Health Act draft legislation makes clear that one of the ways that the sponsors of the bill anticipate achieving savings is through reducing waste and fraud in the delivery of healthcare services. In fact, there is an extensive research literature that has examined this issue. This literature has both estimated the level of waste in the service delivery system as well as what level of cost saving would be realistic through enacting structural changes in healthcare service delivery.

One earlier major reference on these questions is a 2010 study by the U.S. Institute of Medicine (IOM).[13] This study identified what it termed a set of "lower bound" estimates of excess health care costs throughout the U.S. in four areas of service delivery.[14] These are: 1) unnecessary services; 2) inefficiently delivered services; 3) missed prevention opportunities; and 4) fraud and abuse. In combination, as of 2010, the IOM's lower-bound estimate of excessive costs in these four areas amounted to 22.4 percent of total personal healthcare spending in the U.S—that is all spending on healthcare other than for administration/profits and public health programs.

Two more recent extensive surveys on this question are those by Shrank et al. (2019) and Speer et al. (2020). These two studies consider evidence for different U.S. population cohorts and take somewhat different approaches in evaluating the relevant findings from the literature. The Speer et al. study provides a lower-end estimate as to the overall level of waste in healthcare service delivery, which they find to be 36.2 percent of personal healthcare spending. The Shrank et al. study addresses a second critical question: how much of this waste could be realistically eliminated through structural reforms in

[11] This overall 9.4 percent savings level is derived as follows:

- Retail drug market savings: 50% saving x 12.5% of total health care expenditures = 6.3% overall savings.
- Wholesale drug market saving: 50% saving x 6.1% of total health expenditures = 3.1% overall savings
- Total savings = 6.3% + 3.1% = 9.4% of overall health care expenditures.

[12] See Pollin et al. (2026) for details on the Biden and Trump limited measures for reduction prescription drug prices.

[13] See Institute of Medicine (2010). As of 2015, the Institute of Medicine was renamed as the "National Academy of Medicine."

[14] The IOM study (Institute of Medicine, 2010) notes overpricing is also common in the areas of medical devices and durable equipment on which we do not focus in this study.

the service delivery system? Their conclusion is that the saving potential is about 44 percent of the total waste in the system under the existing service delivery structure. Bringing together these two sets of estimates suggests a saving potential through structural reforms of service delivery at approximately 16 percent as a share of total personal healthcare spending. That follows if we assume a waste level of 36 percent of total system costs and a potential for reducing that waste at 44 percent (i.e., 0.36 x 0.44 = 0.16).

The next question to consider is what measures could be effective in achieving this level of waste reduction in service delivery? The New York Health Act draft legislation emphasizes one major initiative. This would be to transition out of the fee-for-service payment system that is predominant at present in New York State and throughout most of the U.S. The draft legislation addresses the issue as follows:

> This program will promote movement away from fee-for-service payment, which tends to reward quantity and requires excessive administrative expense, and towards alternate payment methodologies, such as global or capitated payments to providers or health care organizations, that promote quality, efficiency, investment in primary and preventive care, and innovation and integration in the organizing of health care (New York Health Act, 2025, p. 3, under Section 2c).

The two alternative financing approaches referenced in the draft legislation, capitation and global budgeting, are separate techniques for managing large-scale health care budgets. Global budgeting provides lump sum funding at the level of institutions or even geographic regions. By contrast, capitation sets budgets at an individual patient level.

The idea of combining capitation and global budgeting as an integrated delivery system within the U.S. health care system was examined in detail by Hsiao et al. in their 2011 studies on establishing a single-payer health care system for Vermont. Hsiao et al. argue that this system would "create incentives to integrate health care delivery and reduce wasteful and unnecessary health spending," (Hsiao et al., 2011, p. 10, Appendix). Hsiao et al. made what they term a "conservative" assumption that 10 percent savings is feasible through "payment reform and integration of delivery system," with this full savings potential being achievable after 10 years. In a more recent 2021 paper, Hsiao focuses on the saving potential in one particular area of reducing fraud and abuse in the healthcare payment system. He estimates "a plausible lower bound of U.S. healthcare expenditures due to fraud and abuse at around 8 percent and an upper bound around 15 percent," (2021, p. 2). Moreover, Hsiao argues that the savings that could be achieved through reducing fraud and abuse under a single-payer system could be achieved relatively quickly, i.e. within 1 – 2 years once the system is operating fully.

Overall then, combining Hsiao's 10 percent saving estimate through operating a global budgeting system and his low-end figure of 8 percent saving through reducing fraud and abuse brings his lower-end estimate of total saving potential at 18 percent of overall healthcare costs through instituting a single-payer system. Thus, even this lower-end Hsiao saving estimate is still modestly above the 16 percent saving potential figure that we cited above as derived from the two recent survey articles, by Shrank et al. and Speer et al.

Broadly consistent with these estimates, there is also substantial evidence from other countries in which some version of global budgeting and/or capitation has delivered savings in the 8 - 15 percent range.[15]

15 For example, Atlas (2024) reviews the experiences in Canada, Norway, the Netherlands and New Zealand.

Moreover, a global healthcare budgeting framework has been in operation since 2014 in the U.S. state of Maryland. The Maryland financing system operates under federal auspices with the state's Medicare and Medicaid program. Overall, this innovative financing structure in Maryland has been successful. A 2024 evaluation of this model by Mathematica found that "the model has reduced total Medicare spending, reduced preventable hospital use, and improved a variety of quality measures," (Peterson et al., 2024). Similarly, a 2024 study by Atlas found that, between 2014 – 2022, the Maryland single-payer system managed to lower health care costs by nearly 1 percent per year below what was a benchmark rate.

Following from these alternative types of evidence, one could conclude that savings in the range of 6 – 9 percent are achievable as an average over a 10-year period under New York Health.[16] To take the lower-end estimate of what could be achieved within a 5-year period, we will assume that savings of 6 percent of total personal healthcare costs are realistic as an average over a 10-year period. Finally, because personal health care is equal to 90 percent of total health consumption expenditures—with administration/profits and public health programs constituting the other 10 percent of New York's overall health care budget—this personal health care savings of 6 percent is equal to a 5.4 percent savings of total healthcare spending in New York.

Overall Saving Potential

In Table 2, we bring together our estimates as to the three major sources of savings potential under New York Health: reducing administration and eliminating private insurance profits, with 10.2 percent savings; reducing prescription drug prices, with 9.4 percent savings; and service delivery restructuring and payment system design, with 5.4 percent savings. Our estimate of total savings potential through the New York Health single-payer system therefore amounts to amounts to 25.0 percent of overall health consumption expenditures in the state.

TABLE 2. Sources of Estimated Cost Savings Under New York Health

	Percentage Cost Savings in Total Health Consumption Expenditures under New York Health
Reducing Administration and Eliminating Insurance Profits	-10.2%
Reducing Prescription Drug Prices	-9.4%
Service Delivery Restructuring and Payment System Redesign	-5.4%
TOTALS	**-25.0%**

Sources: See Pollin et al. (2026)

[16] The 6 percent average saving figure over 10 years is based on the experience with global budgeting in Marland alone, in which savings of 1 percent every year was achieved relative to a baseline budget figure. The 9 percent saving figure is the average figure over 10 years based on Hsiao's lower-end estimate of 18 percent saving generated through both service delivery control and through reducing fraud and abuse under a single-payer system with global budgeting.

Net Budgetary Impact: Combining Cost Increases and Saving Potential

Having now reviewed the major sources of potential cost increases and cost savings under New York Health, we can generate an estimate of the overall budgetary impact of implementing New York Health relative to total health consumption expenditures, as of 2024, under New York's existing health care system. Our overall results are presented in Table 3.

TABLE 3. Estimated Net Budgetary Impact on New York State Health Consumption Expenditures under New York Health (2024 figures)

Overall 2024 Health Consumption Expenditures decline by 12.0 percent through New York Health

Areas of cost increases and savings	**Budgetary impact on health consumption expenditures**
1. Actual health consumption expenditures, 2024	$401.1 billion
2. Increase in health consumption expenditures within existing system through: -- universal coverage -- expanded long-term care ; and -- increased healthcare professional rates	$73.8 billion
3. Total health consumption expenditures with universal coverage, expanded long-term care coverage and increased healthcare professional rates with existing system	$474.9 billion *(20% cost increase; = rows 1 + 2)*
4. Decrease in health consumption expenditures under NYHA with system-wide cost savings through: -- reducing health insurance admin and private profits -- reducing prescription drug prices -- service delivery restructuring and payment system redesign *(= 25.0% saving relative to row 3 total cost)*	$118.7 billion *(=row 3 x 0.25)*
5. Total health consumption expenditures with universal coverage, expanded long-term care, and increased healthcare professional rates with system-wide cost savings	$356.2 billion *(= row 3 – row 4)*
6. CHANGE IN HEALTH CONSUMPTION EXPENDITURES THROUGH NEW YORK HEALTH	***-$44.9 billion (=row 5 – row 1)***
15. % CHANGE IN HEALTH CONSUMPTION EXPENDITURES THROUGH NEW YORK HEALTH	***-11.2%*** *(=row 6/row 1)*

Sources: See Pollin et al. (2026).

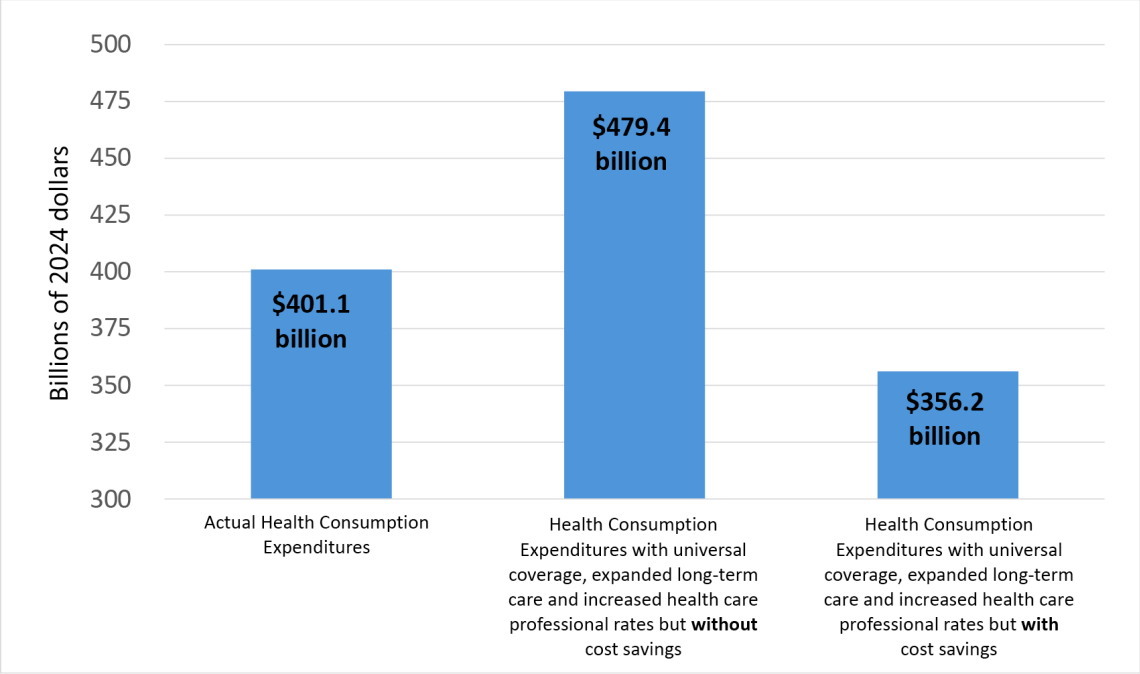
As Table 3 shows, we include the three areas of cost increases—providing full universal insurance coverage with no cost sharing; restructuring long-term care and expanding paid home care provision; and setting average healthcare professional payment rates at 130 percent of current Medicare rates. We conclude that these three features of New York Health will generate $73.8 billion in increased costs under the existing system. This equals a total gross cost increase of 18.4 percent relative to New York's 2024 expenditure level, from $401.1 billion to $474.9 billion.

We then estimate three areas of cost savings that result through New York Health. These include reducing administration and eliminating insurance company profits; reducing prescription drug prices; and restructuring service delivery and payment systems. Our estimate is that these three areas will generate 25.0 percent in savings. This amounts to a savings of $118.7 billion, bringing the $474.9 billion health expenditure figure down to $356.2 billion under New York Health. Figure 1 summarizes these results.

Thus, after accounting for all of these areas of cost increases and savings under New York Health, we estimate that implementing New York Health can generate a net savings of $44.9 billion (i.e., $73.8 billion in cost increases - $118.7 billion in cost savings). This is equal to 11.2 percent of New York State's total Health Consumption expenditures.

FIGURE 1: New York State Health Consumption Expenditures: Actual and Estimated under New York Health

Figures are for 2024 exclusive of public health spending



Sources: See Pollin et al. (2026).

4. How to Finance New York Health

The overall funding requirement for New York Health will include the $356.2 billion to cover in full universal insurance coverage, expanded long-term care benefits and compensation increases for healthcare professionals. It will also include three other funding needs. These are:

- $17.7 billion to compensate for federal government cutbacks in support for Medicaid and the ACA.
- $8 billion to compensate for the funding that local governments have been contributing to Medicaid in New York State;
- $6.0 billion to support workers displaced through the phase-out of private insurance programs, an issue which we review below.

These additional funding areas amount to $31.7 billion. Adding these funding requirements to our estimated baseline budget of $356.2 billion brings the total funding requirement for New York Health to $387.9 billion.

There will be two basic sources to cover this full $387.9 billion funding requirement. The largest funding source will be the same public health care revenue sources that are presently providing $254 billion for health care in New York State, amounting to about 63 percent of all health care funding in the state. The second funding source will need to be new tax revenues.

Of course, under New York Health, households and businesses will no longer be making payments to private insurance companies. They will instead pay taxes to New York State as the alternative to payments they presently make to the private health insurance companies. For most categories of households and businesses, their net health care costs will decline under New York Health. That is, the amounts they will pay in taxes under New York Health will be less than what they currently pay to private health insurance companies. Moreover, these health care cost savings under New York Health will be significant for most categories of households and businesses.

With respect to the public funding sources, the New York Health Act bill is explicit in stating that it will work to obtain authorization to utilize existing federal funds to support financing New York Health — what is termed a federal "waiver." But in the event that federal waivers are not forthcoming, the bill presents an alternative approach, termed a "wraparound" financing structure. Under the wraparound structure, the existing federal programs would continue to operate under their existing arrangements. New York Health would then provide complementary forms of support alongside these programs.

Either under a waiver or wraparound arrangement with respect to federal funding, we estimate that the amount that New York Health will need to raise in new tax revenues should be $133.9 billion, as we show in Table 4. But as we discuss below, it is possible that New York State will need to either raise more tax revenue or reduce some of its spending priorities under a wraparound arrangement. This will primarily depend on what are established as the specific provisions between New York State and the federal government under a wraparound arrangement.

TABLE 4. Additional Public Revenues Required to Finance New York Health, 2024

Funding requirements for full universal coverage, long-term care expansion, increased provider rates, Medicaid offsets and just transition support	$387.9 billion
All current public sources of financing	$254.0 billion
Additional financing required *(= rows 1 – 2)*	$133.9 billion

Sources: See Pollin et al. (2026).

Tax Proposal for Generating $133.9 Billion in Revenue

There are, of course, numerous combinations of tax measures that could be capable of raising the necessary $133.9 billion in revenues to support New York Health. The proposal we present here is meant to be illustrative, to demonstrate, most importantly, one approach through which the needed revenues would be raised in full while also delivering significant net financial gains for most New York households and businesses relative to what they now pay for their health care coverage. Our proposal includes five separate taxes. These are: 1) a payroll tax; 2) a non-payroll tax, i.e. on interest, dividends, capital gains and self-employment income; 3) a gross receipts tax on businesses; 4) a sales tax on individuals and families; and 5) a wealth tax on individuals and families. Table 5 shows the tax rates, with exemptions and credits, that we estimate will generate the $133.9 billion in necessary revenue under this proposal.

TABLE 5. Illustrative Tax Proposal to Finance New York Health

Payroll Taxes *Businesses cover 80% of payroll tax*	
Incomes below $28,850	0
Incomes between $28,850 and $148,200	1%
Incomes above $148,200	2%
Non-payroll Taxes *(on interest, dividends, capital gains, and self-employment income)*	
Incomes below $28,850	0
Incomes between $28,850 and $148,200	6%
Incomes above $148,200	12%
Sales Tax on Non-Necessities	3.5%, *-- with 2.5% tax credit for Medicaid eligible families*
Wealth Tax	0.7% *-- with exemption for first $1 million*
Business Gross Receipts Tax	1% *--- with exemption for first $1 million in revenue*

Source: See Pollin et al. (2026).

Tables 6 and 7 then show the distributional impact of these taxes on representative families at different income levels and businesses of different sizes. Specifically, we show in Tables 6 and 7 how much each representative family or business cohort would pay in taxes under New York Health relative to what they presently pay for private health insurance and out-of-pocket expenses. As we show, net health care costs will decline under New York Health for most categories of households and businesses.

Table 6. Distributional Impacts of Illustrative Tax Proposal on Families

	Health care spending/income	***Change* in health care spending/income**
Low-income families		
$15,200 in income with Medicaid	-0.7%	-5.1%
$48,300 in income, uninsured	1.6%	-3.1%
Middle-income families *$87,100 in income*		
Underinsured	0.9%	-8.6%
Individually insured	0.9%	-13.5%
Insured by employer	0.9%	-3.4%
High-income families		
Top 20%	3.6%	+2.4%
Top 5%	5.7%	+5.7%

Source: See Pollin et al. (2026).

TABLE 7. Distributional Impacts of Illustrative Tax Proposal on Businesses

	Change in Health care spending	**Change in health care spending/gross receipts**
Small businesses—0 – 9 employees		
--no current health benefits	---	+0.2%
--with health benefits	-91.7%	-1.1%
Medium-sized businesses		
10 – 19 employees	-15.8%	-0.2%
20 – 99 employees	-7.4%	-0.1%
Large businesses		
100 – 499 employees	-36.7%	-0.6%
500+ employees	-33.6%	-0.6%

Source: See Pollin et al. (2026).

Thus, with households, health care costs will fall for all low- and middle-income families. The decline in health care spending as a share of income will range between about 3 and 14 percent for these families. Health care spending will rise for high income families, with the range of increased spending being between about 2 and 6 percent as a share of income. But these spending increases for high-income families are from very low spending levels under the existing system, after accounting for the health care subsidies that high-income families currently receive. In fact, we estimate that, in 2024, the richest 5 percent of New York families received a health care subsidy of $21,020 that more than compensates for the $20,510 they paid in insurance premiums and out-of-pocket expenses.

With respect to the representative businesses, the only category that will experience increases in health care costs will be small firms—those with 9 employees or less—that currently provide no coverage for their average number of 3 employees. We estimate that, on average, these firms will pay $1,350 in payroll taxes under New York Health while being exempt from paying the gross receipts tax. This $1,350 in payroll taxes amounts to 0.2 percent of the $877,400 in average gross receipts for these small firms.

Along with this, the largest reductions in business health care costs will be for small firms that are currently covering at least some of their employees. These firms will see their health care costs fall by over 90 percent relative to what they currently spend. Large firms will see their health care spending fall in the range of 35 percent.

5. The Transition to New York Health

As a $400 billion enterprise, the transition out of New York's existing health care system into New York Health will of course entail significant challenges. There will be four major sets of issues to tackle: 1) the overall administrative transition; 2) the impact of the transition on both the incomes of healthcare professionals and on the capacity of these providers to meet the increased demand for health care services under universal coverage; 3) the displacement of workers now employed in both the private health insurance and health services industries; and 4) implementing New York Heath under a wraparound structure in the event that the federal government does not provide waivers for releasing federal funds into the state's single-payer system. We briefly consider these in turn.

The Administrative Challenge

Once New York Health passes into law, the state's health care system would need to transition the $400 billion enterprise out of its existing mixed public and private multi-payer insurance system into a public single-payer system. There will be four main transition paths for bringing all New York residents under the New York Health umbrella: 1) out of the existing public plans; 2) out of employer-based private plans; 3) out of non-group private plans; and 4) integrating the currently uninsured. We consider two broad phase-in approaches, a four-year plan and a one-year plan. Considering a range of factors that will be at play during this transition, we conclude that, in fact, the shorter, one-year phase-in will be less challenging to implement than the four-year approach.

One relevant point is that, between Medicare, Medicaid as well as all military health insurance programs, roughly 43 percent of New York residents are already covered through a public-sector insurance plan. Transferring all of these people onto New York Health will therefore entail only moving them from one government-based accounting entity to another. Another 47 percent of New York

residents are covered through their employers. The procedures involved in transitioning employees between health plans are already familiar to virtually all businesses that current provide health insurance coverage. For example, a 2024 survey of 2,000 employers found that 53 percent of the employers were planning to make changes to their health insurance plans in 2025. The fact that most businesses will achieve significant savings under New York Health relative to their current healthcare expenditures will also incentivize them to complete the transition as quickly as possible.

Previous experiences with implementing new health care systems also demonstrate that relatively short-term transitions are workable. This includes the phase-in during the initial establishment of Medicare in the United States in 1965-66, which was implemented without benefit of modern information technology systems. This is also true for the implementation of the respective universal single-payer systems in Taiwan in 1995 and Canada, starting in 1947.

Impact on Providers and Recipients' Access to Providers of Choice

As we have discussed above, we have incorporated into our budgetary estimates that payment rates for healthcare professionals under New York Health will increase to an average of 130 percent of current Medicare rates within a global budgeting framework. At present, average physician compensation rates are, on average, 64 percent higher than current Medicare rates with private insurance, while they are 31 percent lower than current Medicare rates through Medicaid. We estimate that establishing an average compensation rate for New York physicians at 130 percent of current Medicare rates will increase their average compensation by 17 percent.

In addition, average income for physicians will increase further because New York Health will significantly reduce their administrative burdens. For physicians, we estimate that their administrative work time will decrease by an average of 40 percent under New York Health. This will enable the physicians to increase their billable hours by about 13 percent. Assuming physicians maintained their existing average 49-hour workweek, we estimate that average physician incomes could rise in the range of 30 percent due to both the higher compensation rates and the increase in billable hours.

The increase in physicians' time for direct patient care, as opposed to administrative matters, will also mean that, for the most part, the existing supply of physicians will be sufficient to meet the increased demand for care resulting from universal health coverage. This also suggests that care recipients should not face difficulties in continuing to receive care from their preferred providers. To the extent that possible modest shortages of physicians' time could result through implementing New York Health, such shortages can be filled through the existing pool of nurse practitioners in the U.S. As of 2023, there was a large oversupply of nurse practitioners in the U.S. relative to the numbers currently employed—with 258,000 employed nurse practitioners employed out of a total pool of 385,000. That is, there were 127,000 unemployed nurse practitioners, amounting to roughly 50 percent of those who are employed. In New York State, nurse practitioners are both trained and licensed to diagnose and treat common illnesses and injuries, manage chronic illnesses, prescribe medications and practice independently. They also have substantial authority to practice independently.

Just Transition for Displaced Workers

The implementation of New York Health will produce significant job losses for workers now employed in the private health insurance industry, as well as administrative support staffers devoted to health insurance matters within the health care services industry. Overall, we estimate that full

implementation of New York Health will entail employment losses of about 113,000 jobs in all areas of private health insurance administration, both among private insurance carriers and in the offices of health care providers. This is equal to about 1 percent of the New York State workforce.

Providing fair levels of support and protections for these workers will need to be a major component of the overall transition process, as is recognized in the draft New York Health Act bill. Levels of support should include full pension guarantees for all workers; a path to voluntary retirement for older workers that would include wage replacement as well as pension guarantees; and an average of one year of 100 percent wage replacement. It should also include retraining, relocation, and job placement support for displaced workers.

We estimate the total costs of this level of support for the 113,000 workers whose jobs will become redundant will be $10.5 billion. The annual costs of the program will depend on how quickly New York Health is phased in. For example, if the full just transition features of New York health are phased in over two years, the annual costs of the program will be $5.3 billion per year. As noted above, we have allocated a total of $6.0 billion per year on just transition programs, equal to about 1.7 percent of the overall annual New York Health budget.

Federal Government Funding via Waivers or Wraparounds

In order for the funding from the federal government to be transferred into the New York Health operating budget, the New York State government will have to obtain waiver approvals from the federal government. The New York Health Act draft bill explicitly states its intention to obtain these waivers.

For the federal waiver applications to be approved, New York State will have to demonstrate that New York Health will provide coverage that is at least as comprehensive and extensive as well as no more costly for New York State residents than the coverage they currently receive from existing federal programs. New York Health will certainly meet all of these criteria. Despite this, it cannot be assumed that the federal government will agree to grant these waivers.

As such, the draft bill presents an alternative wraparound framework for operating New York Health. Under this structure, all existing federal programs would continue to operate under their existing arrangements. New York Health would then provide complementary forms of support alongside these federal programs. As one important example, under Medicare's hospital coverage (Part A), outpatient services (Part B) and prescription drug support (Part D), enrollees are responsible for paying premiums, deductibles, and copayments. Under the wraparound provisions, these out-of-pocket Medicare costs would be covered by New York Health. State residents will therefore still face no out-of-pocket costs within the framework of New York Health, regardless of whether the federal government releases Medicare and Medicaid funding via its waiver authority. New York State does currently operate with multiple wraparound programs, including the Elderly Pharmaceutical Insurance Coverage (EPIC) program, the New York State Health Insurance Program (NYSHIP), and the Qualified Medicare Beneficiary (QMB) program.

Operating New York Health through a wraparound structure would increase the administrative requirements of the program. We estimate that the additional administrative costs would total to about $1.2 billion. This is equal to about 0.3 percent of the estimated total budget of New York Health.

It is possible that the costs covered by the state of financing New York Health under a wraparound arrangement could increase significantly more, by as much as $20 billion, or 5.5 percent of the system's

overall budget. This possibility would arise if, under the wraparound arrangement, New York State business owners are not able to continue receiving the federal tax deduction currently provided to them when they purchase health insurance for their employees.

In fact, New York businesses should continue to receive this federal tax benefit, since, under New York Health, the businesses would still be paying for their employees' health insurance coverage through their payroll and gross receipts tax obligations. Yet, whether business owners would continue to receive this federal tax benefit under a wraparound arrangement would likely end up being adjudicated in the state and federal courts.

If it is established in the courts that this federal tax benefit for businesses would no longer be forthcoming under a New York Health wraparound structure, the state would then have to proceed to some combination of either raising more tax revenue at the state level or reducing some of the benefits provided under New York Health. As one example, increasing the wealth tax rate from the 0.7 percent figure that we have proposed to 1.0 percent would itself generate virtually all of the additional funds required if, under the wraparound arrangement, New York business owners were to lose their current tax benefit for providing health insurance to their employees.

6. Conclusion

Health outcomes in the United States are significantly inferior to those of all other high-income countries, even while the U.S. spends roughly 50 percent more on health care as a share of the economy relative to the other high-income countries. In this backgrounder, we show how a universal health care system—i.e. a 'single-payer' or 'Medicare for All' system—can transition the United States out of this current untenable situation. We show how a U.S. single-payer health care system can deliver good-quality care to the whole population while concurrently achieving major cost savings relative to the existing system. Our focus in this paper has been on the prospects for achieving a single-payer system at the level of one state, i.e. New York State. But the basic issues on which we focus for the New York State proposal will also be central for all other state-level single-payer proposals as well as for the U.S. case overall. This becomes clear in reviewing the issues around the U.S.-level Medicare for All proposals advanced in the U.S. Congress in recent years by Senator Bernie Sanders and Congresswoman Pramila Jayapal.

We show how the single-payer proposal for New York State—the New York Health Act—can deliver universal coverage, expanded long-term care support and higher average compensation levels for the state's health care professionals while still lowering overall health care costs in the range of 11 percent. Within this structure, we show that most individual households and businesses will experience cost savings relative to what they now pay for health care through their insurance premiums, deductibles, copayments and other out-of-pocket expenses. In most cases, these savings for individual households and businesses will be substantial. We also show how the set of transition challenges can be successfully managed in implementing the New York Health system.

One final consideration in assessing the New York Health Act proposal is also critical: it has already passed the New York State Assembly five separate times between 1991 and 2018 and now also has significant support in the State Senate. The New York Health proposal thus offers the prospect of serving as a first major breakthrough toward establishing good-quality health care coverage to the entire U.S. population as a moral imperative.

REFERENCES

Aspinall, S. L., Sales, M. M., Good, C. B., Calabrese, V., Glassman, P. A., Burk, M., Moore, V. R., Neuhauser, M. M., Golterman, L., Ourth, H., Valentino, M. A., & Cunningham, F. E. (2016). Pharmacy Benefits Management in the Veterans Health Administration Revisited: A Decade of Advancements, 2004-2014. *Journal of Managed Care & Specialty Pharmacy*, *22*(9), 1058–1063. https://doi.org/10.18553/jmcp.2016.22.9.1058

Atlas, B. (2024). Hospital Global Budgeting: Lessons from Maryland and Selected Nations. Commonwealth Fund. https://doi.org/10.26099/p3nn-5f02

Collins, S. R., & Gupta, A. (2024). The State of Health Insurance Coverage in the U.S.: Findings from the Commonwealth Fund 2024 Biennial Health Insurance Survey. The Commonwealth Fund. https://doi.org/10.26099/BYCE-QC28

Euhus, R. Williams, E., Burns, A. & Rudowitz, R. (2025, July 23). Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package. KFF. https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/#

Frakt, A. B., Pizer, S. D., & Feldman, R. (2012). Should Medicare adopt the Veterans health administration formulary? *Health Economics*, *21*(5), 485–495. https://doi.org/10.1002/hec.1733

Gagnon, M.-A., & Wolfe, S. (2015). *Mirror, mirror on the wall: Medicare Part D pays needlessly high brand-name drug prices compared with other OECD countries and with US government programs* [Policy Brief]. School of Public Policy and Administration, Carleton University. Public Citizen. https://www.citizen.org/wp-content/uploads/2269a.pdf

Glass, R. (2026). Universal Coverage Debate Health Up in Several States. Mercer. https://www.mercer.com/en-us/insights/us-health-news/universal-coverage-debate-heating-up-in-several-states/

Health Affairs Forefront. (2022). *The Role Of Administrative Waste In Excess US Health Spending* (Considering Health Spending) [Research Brief]. Health Affairs. https://www.healthaffairs.org/content/briefs/role-administrative-waste-excess-us-health-spending

Hsiao, W.C. (2021) Fraud and Abuse in Healthcare Claims, Harvard School of Public Health

Hsiao, W. C., Kappel, S., & Gruber, J. (2011). Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont. Harvard School of Public Health.

Iacurci, G. (2026, March 6). GOP 'big beautiful bill' poised to deliver 'shock' to ACA marketplace, health policy experts say. CNBC. https://www.cnbc.com/2026/03/06/gop-big-beautiful-bill-to-deal-shock-to-the-aca-marketplace.html

Institute of Medicine (IOM). (2010). *The healthcare imperative: Lowering costs and improving outcomes: Workshop Series Summary* (P. L. Yong, R. S. Saunders, & L. Olsen, Eds.). The National Academies Press.

Levy, H. and Buchmueller, T. C. 2025. The Impact of Health Insurance on Mortality. *Annual Review of Public Health, 46*: 541-550. https://doi.org/10.1146/annurev-publhealth-061022-042335

Marchildon, G. (2025). Tommy Douglas and the Quest for Medicare in Canada (1st ed). University of Toronto Press.

Mulcahy, A. W., Schwam, D., & Lovejoy, S. L. (2024). *International Prescription Drug Price Comparisons: Estimates Using 2022 Data*. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA788-3.html

Neuman, P., Strollo, M. K., Guterman, S., Rogers, W. H., Li, A., Rodday, A. M. C., & Safran, D. G. (2007). Medicare Prescription Drug Benefit Progress Report: Findings From A 2006 National Survey of Seniors: The first in-depth look at the characteristics and experiences of seniors since the implementation of the Medicare drug benefit. Health Affairs, 26(Suppl2), w630–w643. https://doi.org/10.1377/hlthaff.26.5.w630 et al., 2007)

New York Health Act, S3425, The New York Senate 2025-2026 Legislative Session (2025). https://www.nysenate.gov/legislation/bills/2025/S3425

Peterson, G., Rotter, J., Machta, R., Calkins, K., Lee, K. M., Markovitz, A., Sarwar, R., Stewart, K., Vogler, J., & Platt, I. (2024). *Evaluation of the Maryland Total Cost of Care Model: Progress Report* (Prepared for: U.S. Department of Health and Human Services, Center for Medicare & Medicaid Innovation). Mathematica. https://www.mathematica.org/publications/evaluation-of-the-maryland-total-cost-of-care-model-progress-report

Pollin, R, Heintz, J., Arno, P., Wicks-Lim, J., and Ash, M. (2018) Economic Analysis of Medicare for All, Political Economy Research Institute, https://peri.umass.edu/publication/economic-analysis-of-medicare-for-all/

Pollin, R., Wicks-Lim, J. & Arno, P. (2026, *forthcoming*). Economic Analysis of the New York Health Act Single Payer Proposal. Political Economy Research Institute.

Shrank, W. H., Rogstad, T. L., & Parekh, N. (2019). Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*, *322*(15), 1501–1509. https://doi.org/10.1001/jama.2019.13978

Sommers, B. D., Gawande, A. A. & Baicker, K. (2017). Health Insurance Coverage and Health – What the Recent Evidence Tells Us. *The New England Journal of Medicine, 377*(6): 586-593. https://doi.org/10.1056/NEJMsb1706645

Speer, M., McCullough, J. M., Fielding, J. E., Faustino, E., & Teutsch, S. M. (2020). Excess Medical Care Spending: The Categories, Magnitude, and Opportunity Costs of Wasteful Spending in the United States. *American Journal of Public Health*, *110*(12), 1743–1748. https://doi.org/10.2105/AJPH.2020.305865

Statistica. (2025). Mortality rates from preventable causes in OECD countries in 2023, by country. https://www.statista.com/statistics/1286558/mortality-rates-from-preventable-causes-oecd-countries-by-country/?srsltid=AfmBOoq7bii0nEMKq3oo25CldkimYOC9TOCB3DJR03iBX43Xmqxt8wpw

The Vatican News. (2026, March 18), "Pope Leo XIV: Health cannot be a luxury for few." https://www.vaticannews.va/en/pope/news/2026-03/pope-leo-xiv-healthcare-for-all-injustice-church-samaritan.html#:~:text=Pope%20Leo%20XIV%20on%20Wednesday,becoming%20a%20cause%20of%20conflict

Telesford, I., Cotter, L., Wager, E. & Cox, C. (2026, March 11). How does health spending in the U.S. compare to other countries? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/

Umland, B., Watts, T., & Patel, S. (2024). *Survey: Employers expect third year of high health cost growth in 2025*. Mercer, Marsh LLC. https://www.mercer.com/en-us/insights/us-health-news/survey-employers-expect-third-year-of-high-health-cost-growth-in-2025/

Vogler, S., Lepuschütz, L., Schneider, P., & Stühlinger, V. (2015). *Study on enhanced cross-country coordination in the area of pharmaceutical product pricing: Final report*. Gesundheit Österreich Forschung- und Planungs GmbH. Publications Office of the European Union. https://doi.org/10.2875/631265

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