Insuring the Uninsured:
The Gains From Reducing Waste

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September 12, 2004

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The United States spends more than twice as much per person on health care as the other rich nations, on average.[2] However, this additional spending does not lead to better health outcomes in the form of life expectancies, infant mortality rates, or self-reported quality of health. The United States does not rank highly in these categories, in fact it ranks it near the bottom among rich countries in both life expectancy and infant mortality rates. In addition, people in the United States have a great deal of insecurity about their access to health care, since alone among wealthy nations, it does not guarantee health insurance for its citizens. Over 70 million people go without health insurance at some point in the year, and in 2003 45 million people went the whole year without insurance.[3]

This paper examines the extent to which it would be possible to pay for covering the uninsured, by eliminating waste within the system. Specifically, it calculates the amount of money that could be saved by replacing the current system, that relies largely on private for profit insurers, with a centralized government run system similar to the traditional Medicare program. It also calculates the potential savings that would result from a national system of bulk drug purchasing or a system of negotiated drug prices, comparable to what exists in Canada and other rich countries. It uses these calculations of savings to determine how many of the uninsured could be covered by the elimination of waste. These calculations are done both for the country as a whole, and for each state.

Before describing the calculations in greater detail, it is worth noting that the calculations in this paper are almost certainly a substantial understatement of the waste in the health care system in the United States. In examining the unnecessary expenses of the for profit health insurance system, this paper only calculates the additional costs associated with running the insurance companies themselves, compared with a Medicare type system. It does not factor in the additional expenses incurred by health care providers – hospitals, physicians' offices, and nursing homes – due to the paperwork necessary to deal with a system of decentralized third party payers. The current system requires many layers of record keeping to determine financial liability that would be largely unnecessary in a centralized system.

The resulting waste in the form of additional administrative personnel at health care providers is substantial. An earlier study placed the size of these unnecessary administrative expenses at between 9.4 percent and 12.2 percent of total health care spending, or between $157.3 billion and $203.5 billion annually, using 2003 health care spending levels.[4] These savings are between $540 and $700 per year for every man,

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[2] This discussion is based on health care statistics from the Organization for Economic Cooperation and Development. This data can be found in the tables in "OECD Health Care Data 2004 – Frequently Requested Data [http://www.oecd.org/document/16/0,2340,en_2649_34631_2085200_119656_1_1_1,00.html] .

[3] See H. Boushey, 2004, "Analysis of the Upcoming Release of 2003 Data on Income, Poverty, and Health Insurance." Center for Economic and Policy Research, [http://www.cepr.net/publications/poverty.htm].

[4] See D. Himmelstein and S. Woolhandler, 1991. "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine*, 324: 1253-1258.

woman, and child in the United States. While the calculations in this earlier paper may somewhat overstate the potential administrative savings at providers, even if the gains from a centralized system are only half as large as this estimate, they would still be enormous.[5] Since it does not include any of the administrative savings incurred by heath care providers, the calculations paper are almost certainly a substantial understatement of the gains from a universal government run health insurance system.

I. Insuring the Uninsured – Gains From a Medicare Type System

This section calculates the number of uninsured who could be insured from the savings that would result from replacing the current system of decentralized private insurers with a centralized Medicare type system. The calculations assume that the only gain from this switch is the difference in the administrative expenses for a Medicare type system compared with the administrative expenses for the current system. Based on data from the Medicare trustees report, the calculations assume that administrative expenses for a universal Medicare type system would be 1.65 percent of health care spending. By contrast, the administrative expenses for the current for profit insurance system are calculated as 15.4 percent of the health care expenses paid out through this system. (See the appendix for a more detailed discussion of the methodology).

Table 1 shows the potential savings from adopting a universal Medicare type system for the country as a whole and in each of the states using data for 2003. The first column of table 1 shows total medical expenditures in 2003 for the country as a whole and in each state. Medicare expenses for the country as whole were $1,673.6 billion in 2003. California spent $181.2 billion on medical care, by far the highest for any individual state.

Table 1
Administrative Savings from Universal Medicare and the Uninsured

	Method I	Method II	Currently Uninsured	Additional Coverage Method I	Method II	Method I	Method II
	(billions of 2003 dollars)		(thousands)				
United States	$1,673.6	$94.7	$155.6	81,834	54,912	90,251	67.1%	110.3%
Alabama	26.4	1.5	2.5	1,167	1,071	1,760	91.8	150.8
Alaska	3.8	0.2	0.4	208	127	208	61.0	100.2
Arizona	24.3	1.4	2.2	1,707	923	1,517	54.1	88.8
Arkansas	13.9	0.7	1.2	801	563	925	70.3	115.5
California	181.2	10.1	16.6	11,945	5,504	9,046	46.1	75.7

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[5] The calculations in the study implicitly assume that the only reason for the difference in administrative costs between the United States and Canada is the difference in the system of providing health insurance. While this undoubtedly the most important factor explaining the differences in costs, there are other factors that could have an impact, most obviously differences in the system of legal liability.

Colorado	22.5	1.4	2.3	1,309	764	1,256	58.4	96.0
Connecticut	25.1	1.4	2.4	767	616	1,012	80.3	132.0
Delaware	5.1	0.3	0.5	185	177	291	95.7	157.3
District of Columbia	7.0	0.4	0.7	163	157	257	96.0	157.8
Florida	98.3	5.5	9.0	4,793	3,286	5,401	68.6	112.7
Georgia	44.8	2.6	4.4	2,499	1,649	2,710	66.0	108.5
Hawaii	7.7	0.5	0.9	346	308	505	88.9	146.1
Idaho	5.6	0.3	0.5	395	234	385	59.3	97.4
Illinois	73.0	4.4	7.3	3,492	2,406	3,955	68.9	113.3
Indiana	35.0	2.1	3.4	1,534	1,317	2,164	85.8	141.1
Iowa	16.8	1.0	1.6	637	621	1,021	97.6	160.4
Kansas	15.5	0.9	1.6	624	580	954	93.0	152.8
Kentucky	23.7	1.3	2.2	1,059	924	1,519	87.3	143.5
Louisiana	27.2	1.3	2.2	1,426	945	1,553	66.3	108.9
Maine	8.1	0.4	0.7	290	282	464	97.3	159.9
Maryland	32.3	1.9	3.2	1,354	957	1,572	70.6	116.1
Massachusetts	49.5	2.7	4.5	1,443	1,265	2,080	87.7	144.1
Michigan	58.7	3.4	5.6	2,538	2,040	3,353	80.4	132.1
Minnesota	33.4	2.1	3.4	1,020	1,117	1,837	109.6	180.1
Mississippi	14.6	0.7	1.2	875	558	916	63.7	104.7
Missouri	34.4	1.9	3.1	1,354	1,181	1,942	87.2	143.4
Montana	4.7	0.3	0.5	246	199	327	81.0	133.1
Nebraska	10.0	0.6	1.0	400	359	591	89.8	147.7
Nevada	9.2	0.5	0.9	700	321	527	45.8	75.3
New Hampshire	7.7	0.5	0.8	259	249	409	96.2	158.1
New Jersey	53.8	3.1	5.1	2,199	1,399	2,299	63.6	104.6
New Mexico	8.8	0.5	0.8	685	340	558	49.6	81.5
New York	141.3	6.7	11.0	5,646	3,348	5,502	59.3	97.5
North Carolina	45.0	2.5	4.2	2,439	1,652	2,716	67.8	111.4
North Dakota	4.4	0.3	0.5	144	175	288	121.7	200.1
Ohio	70.1	4.1	6.7	2,755	2,483	4,080	90.1	148.1
Oklahoma	18.1	1.0	1.7	1,066	703	1,156	66.0	108.5
Oregon	17.8	1.0	1.7	968	654	1,075	67.6	111.0
Pennsylvania	84.5	4.6	7.6	2,804	2,646	4,348	94.4	155.1
Rhode Island	7.4	0.4	0.6	249	224	368	89.9	147.7
South Carolina	21.7	1.2	2.0	1,055	859	1,412	81.4	133.8
South Dakota	4.7	0.3	0.5	180	182	298	100.8	165.7
Tennessee	36.3	2.0	3.3	1,447	1,284	2,110	88.7	145.8
Texas	111.6	6.5	10.7	8,536	4,049	6,655	47.4	78.0
Utah	9.8	0.6	1.0	651	464	762	71.2	117.1
Vermont	3.4	0.2	0.3	136	112	184	82.3	135.3
Virginia	36.7	2.3	3.8	1,836	1,248	2,052	68.0	111.7

Washington	31.8	1.8	3.0	1,639	1,009	1,658	61.6	101.2
West Virginia	11.6	0.7	1.1	465	497	817	106.9	175.8
Wisconsin	32.8	2.0	3.3	1,253	1,202	1,976	95.9	157.7
Wyoming	2.3	0.1	0.2	143	82	134	57.1	93.9

Source: Author's calculations, see appendix.

The second column shows a calculation of the administrative savings for the country as a whole, and for each state, under a universal Medicare type system of health insurance. The calculation shown in this column (identified as "Method 1") focuses narrowly on difference in the administrative costs between the current health insurance system and the administrative costs of the Medicare system. It assumes that this difference would be the only savings that would result from the adoption of a universal Medicare type system. This shows that the country as whole would have saved $94.7 billion in 2003 with a universal Medicare type system. California alone would have saved $10.1 billion with a universal system. Column 3 shows a calculation of the savings, which is derived from a study produced by the Lewin Group, a well respected economics consulting firm. This study estimated the administrative savings to California that would result from the adoption of a universal type Medicare plan. (It also examined the costs of other health care reforms.)[6] This estimate provides a useful check for the calculation developed in this study, and supports the view that it is genuinely a low-end estimate of the potential savings from a universal Medicare type system. The calculation derived from the Lewin analysis indicates that the United States as whole would have saved $155.6 billion in administrative expenses in 2003, with a universal Medicare type system, while California alone would have saved $16.6 billion.

The fourth column shows the number of people who are without insurance at some point in the year. These data are taken from an analysis of Census Data (Families USA, 2004) for 2002, the most recent data available. The data show that nationwide, 81,834,000 people were without insurance at some point in the year. In California, 11,945,000 were without insurance at some point in the year.

Columns 4 and 5 show the number of uninsured who could be insured with the savings from the adoption of a universal Medicare type system. Using the first method of calculating waste, Column 4 shows that 54,921,000 people could be insured nationwide with the savings. In California, the savings could insure 5,504 million people. Column 5 shows the number of people that could be insured using the calculations of savings from Method II. This shows that 90,251,000 could be insured nationwide with these savings, and 9,046,000 could be insured in California alone.

Columns 5 and 6 show the percentage of the currently uninsured population that could be insured with the savings using the two methods of calculation. Column 5 shows that 67.1 percent of the uninsured nationwide could be insured with the administrative savings as calculated using Method I. It shows that 46.1 percent of the uninsured in California could

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[6] This analysis can be found at www.healthcareoptions.ca.gov .

be covered by the savings calculated with Method I. Column 6 shows that the savings, as calculated with Method II would be large enough to pay for the coverage of the entire uninsured population – 110.3 percent of the uninsured. While this would not necessarily be the case in every state, the savings would go quite far towards this goal. In California, for example, the administrative savings as calculated using Method II would be large enough to insure 75.7 percent of the uninsured population.

In short, this analysis shows that even under extremely conservative assumptions, the savings from adopting a universal Medicare type system would be large enough to pay for insurance for the vast majority of the uninsured. If the efficiencies areas large as those assumed by the Lewin Group in its analysis, then the savings would be large enough nationwide to insure all of the currently uninsured population. This would be the case in the vast majority of states as well.

II. Insuring the Uninsured – The Gains from Bulk Purchases of Prescription Drugs

Consumers in the United States pay far higher prices for prescription drugs than they do anywhere else in the world.[7] The reason is that the United States is the only country that grants drug firms an unrestricted patent monopoly for selling their drugs. In every other country, the government imposes some sort of check on this patent monopoly, usually in the form of price controls or agreeing to a negotiated price with the industry.

In principle, the United States could implement a similar policy where it limits the price that companies charge for their drugs during the period in which they are granted a patent monopoly. There clearly is considerable room for prices to fall, since in most cases the cost of manufacturing and distributing drugs is just a small share of the price. A recent study calculated that the manufacturing and distribution costs accounted for between 5 percent and 15 percent of the standard retail price (Sager and Socolar, 2003). [8]The rest of the price goes to research expenditures, marketing costs, and profits.

The main objection that the pharmaceutical industry has raised to restrictions on it patent monopolies is that lower prices would prevent it from raising the money it needs to finance future research. While the link between current profits and research spending is not as tight as the industry lobbyists imply, they do raise a legitimate point. If the

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[7] The Australian Productivity Commission did an excellent analysis of cross-country spending on prescription drugs which can be found at http://www.pc.gov.au/research/commres/pbsprices/finalreport/pbsprices.pdf. While the purpose of this study was to compare Australian prices with those in other countries, it also provides some basis for comparing the prices paid in other countries. In nearly every comparison, the prices paid in the United States were by far the highest, often being more than twice as much as the average price in paid in other rich countries.
[8] See A. Sager and D. Socolar, 2003. "61 Percent of Medicare's New Prescription Drug Subsidy is Windfall Profit to Drug Makers," Health Reform Program, Boston University School of Public Health, [http://www.healthreformprogram.org].

government sets prices through a negotiation process or outright controls, it will effectively be determining the course of future research spending. The industry will steer its research dollars towards areas in which government negotiators/price setters have allowed large profit margins.

In recognition of this fact, Congressman Dennis Kucinich has proposed a bill, "The Free Market Drug Act," which eliminates the need to rely on patent monopolies to finance drug research. This bill would effectively double the current amount of public funding for drug research, with the funded agencies taking over responsibility for developing and testing drugs. Under the provisions of this bill, patents for the drugs developed with public funding would be placed in the public domain, so that these drugs could be sold in a competitive market, just as generics are presently.[9]

The system of negotiated prices or price controls, along the lines of the Canadian model, and the Kucinich system of direct public funding of prescription drug research with the drugs then sold in a competitive market, provide alternative mechanisms for reducing drug prices. In both cases there would be substantial savings, which could be devoted to other purposes, such as insuring the uninsured.

For purposes of this analysis, it is assumed that adopting a Canadian type system would lead to a reduction in drug prices that averages 50 percent of current prices. This is based loosely on the evidence in the Australian Productivity Commission's report (2???). It is assumed that the Kucinich Free Market Drug would lead to a reduction in drug prices of 70 percent from their current levels – effectively the price that consumers would pay if patented drugs lost their monopolies and they were sold in a competitive market. However, $20 billion of the savings under the Kucinich system would have to be used to finance new drug research, since the industry would no longer have the incentive to finance such research itself.

Table 2 shows the number of people who could be insured with the savings on the cost of prescription drugs in these two scenarios. The first column shows the CMS projections for drug spending for 2005. It is assumed that each state's spending on prescription drugs is proportional to its total spending on health care. The table shows that the country as a whole will spend $233.6 billion on drugs in 2005. California's share of this spending is projected to be $25.3 billion. The second column shows the projected savings assuming that bulk buying allows the government to cut the cost of prescription drugs by 50 percent. The savings for the country as a whole is projected to be $116.8 billion, with the savings for California projected to be $12.6 billion in this scenario.

The third column shows projected savings with the Kucinich Free Market Drug Act. In this case, it is assumed that prices will fall by approximately 70 percent if drugs were sold in a competitive market, although the government would have to increase its spending on bio-medical research by approximately $20 billion annually to replace the

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[9] An outline of this bill can be found at http://www.house.gov/kucinich/issues/freemarketdrugact.htm.

drug industry's spending. In this scenario, the net saving to the country is $143.5 billion, with California receiving $15.5 billion of these savings.

The fourth column shows the number of people currently uninsured nationwide and in each state, the same data shown in the fourth column of table 1. Column 5 shows the number of the uninsured who could be covered with the savings from bulk purchases of prescription drugs. For the country as a whole, these savings would be sufficient to insure 58,384,000 people. In the state of California, these savings would be able to ensure 5,925,000 people.

The sixth column shows the number of people who could be insured with the savings from the Free Market Drug Act. In the country as a whole the savings would be sufficient to insure 71,740,000 people. In California, the savings from having drugs sold in a competitive market would be sufficient to insure 7,281,000 people.

Columns six and seven show the percent of the uninsured that could be covered by the saving from buying drugs in bulk and from selling drugs in a competitive market, respectively. In the country as a whole, 71.3 percent of the uninsured could be covered by these savings. In California, the savings would be sufficient to cover 49.6 percent of the uninsured. The savings under the Free Market Drug Act would be sufficient to cover 87.7 percent of the uninsured nationwide, and 61.0 percent of the uninsured in California.

Table 2
Savings from Bulk Drug Purchases and Competitive Market Pricing

	Current Spending	Savings Bulk Buying	Savings Free Market	Currently Uninsured	Additional Coverage BB	Additional Coverage FM	Additional Coverage BB	Additional Coverage FM
	(billions of current dollars)				(thousands)			
United States	233.6	116.8	143.5	81,834	58,384	71,740	71.3%	87.7%
Alabama	3.7	1.8	2.3	1,167	1,108	1,361	94.9	116.6
Alaska	0.5	0.3	0.3	208	124	153	59.8	73.5
Arizona	3.4	1.7	2.1	1,707	1,001	1,230	58.6	72.0
Arkansas	1.9	1.0	1.2	801	633	778	79.0	97.1
California	25.3	12.6	15.5	11,945	5,925	7,281	49.6	61.0
Colorado	3.1	1.6	1.9	1,309	724	890	55.3	68.0
Connecticut	3.5	1.7	2.1	767	641	787	83.5	102.6
Delaware	0.7	0.4	0.4	185	172	211	93.0	114.3
District of Columbia	1.0	0.5	0.6	163	160	197	98.2	120.6
Florida	13.7	6.9	8.4	4,793	3,564	4,380	74.4	91.4
Georgia	6.3	3.1	3.8	2,499	1,680	2,064	67.2	82.6
Hawaii	1.1	0.5	0.7	346	274	336	79.1	97.2
Idaho	0.8	0.4	0.5	395	238	293	60.3	74.1

Illinois	10.2	5.1	6.3	3,492	2,390	2,936	68.4	84.1
Indiana	4.9	2.4	3.0	1,534	1,342	1,649	87.5	107.5
Iowa	2.3	1.2	1.4	637	638	784	100.2	123.1
Kansas	2.2	1.1	1.3	624	570	701	91.4	112.3
Kentucky	3.3	1.7	2.0	1,059	998	1,226	94.2	115.8
Louisiana	3.8	1.9	2.3	1,426	1,149	1,411	80.6	99.0
Maine	1.1	0.6	0.7	290	310	381	107.0	131.5
Maryland	4.5	2.3	2.8	1,354	956	1,175	70.6	86.8
Massachusetts	6.9	3.5	4.2	1,443	1,371	1,685	95.0	116.7
Michigan	8.2	4.1	5.0	2,538	2,128	2,615	83.8	103.0
Minnesota	4.7	2.3	2.9	1,020	1,072	1,317	105.1	129.1
Mississippi	2.0	1.0	1.3	875	688	846	78.7	96.7
Missouri	4.8	2.4	3.0	1,354	1,299	1,596	95.9	117.9
Montana	0.7	0.3	0.4	246	199	244	80.9	99.4
Nebraska	1.4	0.7	0.9	400	360	442	90.0	110.6
Nevada	1.3	0.6	0.8	700	326	400	46.5	57.2
New Hampshire	7.5	3.8	4.6	259	1,712	2,104	661.0	812.2
New Jersey	1.1	0.5	0.7	2,199	209	257	9.5	11.7
New Mexico	1.2	0.6	0.8	685	380	467	55.5	68.2
New York	19.7	9.9	12.1	5,646	4,262	5,237	75.5	92.8
North Carolina	6.3	3.1	3.9	2,439	1,759	2,161	72.1	88.6
North Dakota	0.6	0.3	0.4	144	167	205	115.8	142.3
Ohio	9.8	4.9	6.0	2,755	2,584	3,175	93.8	115.2
Oklahoma	2.5	1.3	1.6	1,066	749	920	70.3	86.3
Oregon	2.5	1.2	1.5	968	671	825	69.4	85.2
Pennsylvania	11.8	5.9	7.2	2,804	2,914	3,581	103.9	127.7
Rhode Island	1.0	0.5	0.6	249	257	316	103.2	126.8
South Carolina	3.0	1.5	1.9	1,055	918	1,128	87.0	106.9
South Dakota	0.7	0.3	0.4	180	177	217	98.1	120.6
Tennessee	5.1	2.5	3.1	1,447	1,406	1,728	97.2	119.4
Texas	15.6	7.8	9.6	8,536	4,191	5,150	49.1	60.3
Utah	1.4	0.7	0.8	651	432	531	66.4	81.6
Vermont	0.5	0.2	0.3	136	122	150	89.8	110.3
Virginia	5.1	2.6	3.1	1,836	1,201	1,476	65.4	80.4
Washington	4.4	2.2	2.7	1,639	1,052	1,292	64.2	78.8
West Virginia	1.6	0.8	1.0	465	524	644	112.8	138.6
Wisconsin	4.6	2.3	2.8	1,253	1,173	1,441	93.6	115.0
Wyoming	0.3	0.2	0.2	143	78	96	54.5	67.0

Source: Author's calculations, see appendix.

Appendix

The first column in table shows national and state by state medical spending for 2003. The data for the national spending is taken from the CMS National Health Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1990-2013 (table 3) [http://www.cms.hhs.gov/statistics/nhe/projections-2003/t3.asp]. The spending data for individual states was derived from the CMS "Trends in State Health Care Expenditures and Funding, 1980-1998." Table 2, Personal Health Care Expenditures and Average Annual Percent Growth, by Regional and State: United States, Selected Calendar Years 1980-1998, [http://www.cms.hhs.gov/statistics/nhe/state-trends/t2.asp]. The state data for 1998 were multiplied by the ratio of national spending in 2003 to national spending in 1998, effectively assuming that each state's share of health care spending did not change in this five-year period.

The second column shows an estimate of savings based on the assumption that spending that is currently paid through private insurers is instead paid through a universal Medicare type system. The estimate of total payments by private insurers and other third party payers for 2003, $687.6 billion, is taken from, CMS 2004, National Health Expenditures Projections, Table 3 [http://www.cms.hhs.gov/statistics/nhe/projections-2003/t3.asp] Table 3 National Health Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1990-2013. The estimate of the administrative costs incurred by these insurers and third parties ($106.0 billion) is taken from Bureau of Economic Analysis' National Income and Product Accounts (NIPA, table 2.5.5 line 56). These data give a ratio of administrative expenses to payments of 15.4 percent. By comparison, the administrative expenses of Medicare are equal to 1.65 percent of benefits, this is the ratio of total administrative costs to total expenditures in the 2004 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, table II.B.1.

The second column assumes that the amount of potential savings from introducing a universal Medicare type system is proportional to each state's spending on medical care, after Medicare and Medicaid spending were deducted. State spending on Medicare is assumed to be proportionate to its share of enrollees multiplied by each state's ratio of per capita personal income to the national average. Data on 2003 Medicare enrollees was taken from CMS [http://www.cms.hhs.gov/statistics/enrollment/st03all.asp]. Medicaid spending by state from The Kaiser Commission on Medicaid and the Uninsured, "2002 State and National Medicaid Spending Data, CMS-64" table 1 [http://www.kff.org/Medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=32737]

The third column uses an alternate procedure to calculate the waste eliminated from switching to universal Medicare type system. It relies on an estimate produced by Lewin Group, that the administrative savings in California that would result from the adoption

of a universal Medicare type system would be equal to 9.3 percent of total health care spending **(**Lewin Group's analysis of the Cal Care single payer proposal for California, 2002, figure 17 [http://www.healthcareoptions.ca.gov/]). National savings from the adoption of a universal Medicare type system are assumed to be equal to the 9.3 percent savings in administrative costs that the Lewin Group estimated for California, with each state's savings assumed to be proportional to its share of non-Medicare, non-Medicaid health care spending.

Column 4 shows the number of people who are uninsured at some point in the year for 2003. This data is taken from Families USA analysis of Census Bureau data, "One in Three: Non-Elderly Families Without Health Insurance 2002-2003," [http://www.families usa.org/site/DocServer/82million_uninsured_report.pdf.?docid=3641].

Column 5 shows the number of uninsured that could be covered nationally and each state by dividing the savings as estimated in column 2, by the cost of providing insurance. The latter is assumed to average $3,000 per person. This is based on an estimate of $3,383 for single employee based coverage and $1,786 for single individually purchased insurance. "Update on Individual Health Insurance" Kaiser Family Foundation/ eHealth Insurance P5, August 2004 [http://www.kff.org/insurance/7133.cfm]. This number was multiplied by 0.8623 based on the fact that 13.77 percent of insurance premiums go to unnecessary administrative costs. Furthermore, it is assumed that the average uninsured person is without insurance for two thirds of the year, so that the cost of insuring a person for the whole year is equal to two-thirds of the full-year premium. Each state's insurance cost is assumed be proportional to the ratio of per capita personal income in that state to the national average.

Column 6 does the same exercise based on the estimates of savings from column 3, which are derived from the Lewin Group's estimate. Column 7 is the percentage of the uninsured who could be covered using the projections shown in column 5. Column 8 is the percentage of the uninsured who could be covered using the projections shown in column 6.

The first column in table 2 shows projected national and state by state spending for prescription drugs for 2005. The national figure is taken from , CMS 2004, National Health Expenditures Projections, Table 3 [http://www.cms.hhs.gov/statistics/nhe/projections-2003/t3.asp] Table 3 National Health Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1990-2013. State spending figures are assumed to be proportional to state spending on healthcare, which is taken from CMS "Trends in State Health Care Expenditures and Funding, 1980-1998." Table 2, Personal Health Care Expenditures and Average Annual Percent Growth, by Regional and State: United States, Selected Calendar Years 1980-1998, [http://www.cms.hhs.gov/statistics/nhe/state-trends/t2.asp]. Column 2 shows projected savings assuming that bulk buying of prescription drugs reduces the cost nationally, and in each state, by 50 percent. Column 3 shows projections that assume that allowing drugs to be sold in a competitive market (without patent monopolies) will reduce the cost of

buying drugs by 70 percent. The projection for national savings deducts $20 billion from this estimate to cover the cost of additional publicly supported drug research (see Baker and Chatani 2002, "Promoting Good Ideas on Drugs: Are Patents the Best Way?, Center for Economic and Policy Research,
[http://www.cepr.net/promoting_good_ideas_on_drugs.htm]). The state level savings are assumed to be proportional to each state's share of national health care spending.

The number of uninsured who could be covered shown in columns five and six are calculated in the same way as in columns five and six of table one. Similarly, the percentage of the uninsured who can be covered with the savings from lower cost drugs, shown in columns seven and eight, are calculated in the same way as in columns seven and eight of table 1.